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SOME CLINICAL NOTES IN OPHTHALMOLOGY.

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Read before the San Francisco Medico-Chirurgical Society.

The following notes are taken from memoranda made during a stay of three years in the east and in Europe, and contain such material as seemed worthy of mention, either on account of its novelty, or by reason of its presenting the views of leading ophthalmologists.

Subconjunctival Injections.—The question of subconjunctival injections has been attracting much attention during the past two years, and the opinions of leading clinicians vary greatly as to the efficacy of this mode of treatment.

Darier, former assistant in the clinic of Abadie, of Paris, has used them very extensively, and his opinion is, in the main, favorable. Abadie continues to make use of them, and has added several cases, recently, to the number of those treated successfully by this method. DeWecker esteems sublimate injections very highly in cases of hypopion ulcers and interstitial keratitis, but is less confident of their value in affections of the uveal tract.

Deutschmann is very enthusiastic in his recommendation of this treatment in infectious processes. Fuchs has found no better results from them than from other therapeutic measures. Edouard Meyer, who impresses one as being very reliable and conservative, and yet, withal, progressive, says he has not observed any beneficial effect from their use in his clinic.

Dr. Carl Mellinger, of Basel, found that the same benefit followed the use of $\frac{3}{4}$ to 2 per cent. salt solutions, and is, therefore, of the opinion that the beneficial effect, if any, is due to the stimulation of a freer lymph circulation. He considers the latter solution even superior to the sublimate, which is often followed by inflammatory adhesions of the conjunctiva to the underlying tissues, and, in some cases, by iritis.

Chronic Vascular Keratitis.—Inflammatory conditions of the cornea, accompanied by the formation of vessels, leave indelible traces behind them, after the subsidence of the more active symptoms. Such corneæ are liable to frequent exacerbations of the inflamma-

tory symptoms, in which the old vessels, visible only under a powerful lens, as white marks, refill and cause serious interference with vision.

DeWecker and Masselon practise the excision of the portion of conjunctiva containing such vessels, and in the more severe cases, this amounts to the removal of a strip of conjunctiva extending completely around the cornea. The wound heals smoothly, and no harm results from the retraction of the conjunctiva.

Chronic Episcleritis.—Any addition to our scanty resources for combating this disease, so trying alike to patient and medical attendant, will be welcomed by those who have already exhausted the ordinary therapeutic measures. At the Quinze-vingt Hospital, cauterization is the favorite method. A number of punctures—five or six—reaching down to the sclera, are made with the actual cautery. The results are said to be much more favorable than those derived from conservative treatment.

Trachoma.—Many cases of trachoma are manifestly unsuited for expression, and, for such cases, and even as a substitute for the roller forceps, DeWecker has endeavored to apply electrolysis. He uses, for this purpose, a fork-shaped electrode with blunt points. The application of the current causes a destruction of the granulations; however, as each granulation must be attacked separately, and as the reaction is very considerable, electrolysis is not likely to supplant other means.

Epithelioma of the Lids.—The treatment of epithelioma of the lids and orbital region, by means of blue pyoktanin, was advocated, some years since, by a Vienna surgeon. Meyer confirms the results obtained by that author, and adds several cases of his own, in which complete cicatrization and apparent cure resulted from repeated applications of this remedy. He insists upon the necessity of the part being freed entirely from crusts and secretion, by means of 1:5000 sublimate solution, without which, the pyoktanin is inert. He also recommends this drug for ulcerative blepharitis and hypopion ulcers.

Corneal Ulcers.—Sacmich's operation has done good service in cases of infected ulcers with pus in the anterior chamber; however, the surgeons at Moorfield's Hospital resort to corneal incision much less frequently than in former years. The preference now is for the actual cautery, the curative effects of which are often marvelous. The progress of the ulcer is checked, and the hypopion soon becomes absorbed. If the ulcer has already reached the center of the cornea, cauterization is not indicated, lest the interference with vision from

the cicatrix caused by the hot iron be greater than that resulting from the ulceration.

It may be of interest to mention, in this connection, that the late Dr. Martinache, of this city, is credited in Paris with the introduction of this procedure.

Small ulcers, such as follow the removal of minute foreign bodies, and which show, on the following day, signs of infection, are treated by a single application of a 4 per cent. solution of sublimate in glycerine. The solution must be applied with great caution, and care be used that it does not diffuse itself over the healthy corneal tissue.

Catarrhal Conjunctivitis.—The daily application of a 1 per cent. solution of nitrate of silver still holds its place as the most satisfactory treatment in the acute stage of this disease. For the subacute and chronic stages, Mr. Lang, of Moorfield's, has found chloride of zinc, in the strength of $\frac{1}{2}$ grain to the ounce, more effective than any other drug.

Keratoconus.—This peculiar condition, the causes of which still remain undiscovered, is rather unsatisfactory in its response to treatment. Iridectomy and the application of the cautery to the cornea are the two chief methods of treatment. Heretofore, it has always been considered necessary to apply the cautery to the apex of the cone, which coincides usually with the center of the cornea. Mr. Gunn, of the Royal London Ophthalmic Hospital, has discovered, however, that equally good results follow the formation of the eschar slightly eccentric to this point. This modification is exceedingly important, as it does away with the central leucoma, so disturbing to vision.

Strabismus Operations.—The proper age for operating upon cases of strabismus has been the subject of much discussion. The answer to this question seems to depend entirely upon the character of the squint.

DeWecker calls attention to the danger of operating upon cases of concomitant strabismus at too early an age. When to the effect of the operation, that of the proper correcting glass be added, deviation in the opposite direction is likely to follow.

Many surgeons now prescribe the full correction under atropine, continuing the use of a mydriatic until the patient becomes accustomed to the relaxation of the accommodation. The glasses cause frequent complaints, but are much more effective than the old system of partial correction. In any event, DeWecker considers it advisable to defer the operation until the thirteenth year.

In cases of monolateral strabismus, the operation cannot be performed too soon. Whether we accept the theory of amblyopia

exanopsia, or consider the defective vision congenital, the operation should be done at an early age. Landolt prefers the double capsular advancement to a tenotomy, but the greater danger and difficulty of this operation will doubtless prevent it replacing tenotomy.

Enucleation during Panophthalmitis.—So general is the belief that enucleation of the eye during panophthalmitis carries with it grave dangers from meningitis, that few surgeons would care to risk operating at such times. Landolt, however, denies the truth of this belief, and demonstrates his confidence in his opinion by operating during the height of the inflammation. He claims to have experienced no bad results; but one who has observed the difficulty of removing an eye when the tissues are so enormously infiltrated and distended, would not be likely to follow his example.

Lachrymal Stricture Treated by Extirpation of the Palpebral Portion of the Gland.—The inefficiency of operations upon the tear ducts in cases of stricture has caused De Wecker to resort very frequently to the partial extirpation of the lachrymal gland. The operation is by no means a new one, yet it is so seldom practised that a short description of its *technique* may not be out of order:

Cocain anesthesia is sufficient. The upper lid should be drawn strongly upward with a retractor, but not everted. The bulbus being then rolled downward and upward the gland becomes prominent. The lower portion should be dissected out and excised by means of the pincette and scissors. The results of the operation are most satisfactory, and it constitutes a valuable addition to our methods of relieving obstinate cases of tear drop.

Sclerotomy in Cases of Glaucoma.—De Wecker holds that sclerotomy is much safer than iridectomy, when there is great shrinkage of the visual field. He has been trying the method of Prof. de Vincentiis—the so-called internal sclerotomy. The details of the operation are as follows: A slender, slightly-curved knife is passed into the anterior chamber at the corneo-scleral junction. The point is pushed directly across the chamber until it touches the angle of the chamber at a point opposite that of entrance. The handle of the knife being now raised, the point is made to traverse the semi-circumference of the chamber angle, and the knife is then withdrawn. This procedure is supposed to separate the iris from its artificial attachment to the posterior surface of the cornea.

Treacher Collins has shown, recently, by microscopic examination of glaucomatous eyes, upon which iridectomy had been performed, that iridectomy, as it is usually performed, fails to accomplish the desired results. He recommends, therefore, that an

incision be made in the iris, and that it be then torn loose from its ciliary attachment, the portion thus loosened being then excised.

Galezowski claims a large percentage of cures in cases of simple glaucoma, treated by his method of sclerotomy. The operation consists in making four punctures near the corneo-scleral junction with an awl-shaped knife. Four points of the circumference, 90° apart, are selected. The puncture is made at a very acute angle, and is said to pass through the canal of Schlemm in entering the anterior chamber. Should a second operation be found necessary, points midway between the former punctures are selected. Galezowski says that the period of relief afforded by the first operation lasts from one to six months, and that a second or third operation never fails to effect a cure.

Xerosis Conjunctivæ.—Xerosis of the conjunctiva with hemeralopia is endemic in Austria and Russia during the season devoted to religious fasts. A popular remedy for the disease is the ingestion of large quantities of liver. It is interesting in this connection to note that Baas, of Freiburg, calls attention in a recent article to the ocular symptoms sometimes accompanying cirrhosis of the liver. The most prominent of these symptoms are xerosis and hemeralopia.

It is not too much to assume, in view of the now well-recognized value of thyroid extract in cases of myxedema, and of extract of supra-renal capsule in Addison's disease, that liver may possess a similar virtue in cases of xerosis. It is probable that the ocular symptoms are directly traceable to failing action of the liver—the non-production of some essential ferment, or the failure to remove some deleterious substance from the blood. A case treated by this method during my service at Moorfield's Hospital, seemed to improve more rapidly than by the exhibition of simple tonics.

Rupture of the Sclera.—The danger of infection has lead to the invention and successful carrying out of a novel method by De Wecker, in case of rupture of the sclera. He dissects loose the conjunctiva at its corneal attachment, draws it together, and sutures it over the middle of the cornea. The stitches are allowed to remain until they become loose. This procedure was suggested, possibly, by the well-known conjunctival flap of Snellen in cataract extraction. Aseptic closure and firm support to the wound is claimed for this method, and no injury results to the cornea from its temporary covering.

Cataract Extraction.—The German oculists, as a rule, adhere to the plan of extraction with iridectomy. In England opinions are divided upon this subject, a majority, however, of the surgeons at Moorfield's also prefer this method.

Several radical innovations have found favor in Paris. Kalt inserts a suture near the upper border of the cornea, passes the needle again through the episcleral tissue, and allows the loop to hang loosely at the side of the globe during the carrying out of the incision; no iridectomy is made. After the delivery of the lens, the suture is drawn firmly and knotted. His statistics show a reduction of the percentage of prolapse from 8 or 10 to 4. Although the cornea presents a wrinkled appearance immediately following the operation, the degree of astigmatism is said to be less than in operations without suture.

Trousseau makes use of but one instrument in cataract extraction. The thumb and forefinger serve as lid speculum and fixation forceps, and the Graefe knife fills the several offices of cystotome, spatula, and curette. After the knife has entered at the corneo-scleral junction, it is used to open the capsule before making the counter puncture. After completion of the incision, gentle pressure with the knife serves to deliver the lens.

Schweigger continues to use a modified Beer's knife, makes the incision downward, and does no iridectomy.

Snellen performs the simple extraction. The low percentage of prolapse in his practice is ascribed to the fact that he observes the iris for some minutes after the completion of the extraction; replaces it should it tend to fall forward, and instills eserine according to circumstances.

Knapp makes what he calls a peripheral section of the capsule, passing the cystotome well behind the iris. He says that the avoidance of a central scar in the capsule is of great importance; otherwise his operation is the usual extraction without iridectomy.

Nucleus Building.

TUBERCULAR PYELITIS, WITH A REPORT OF THREE NEPHRECTOMIES.

By G. A. WHITE, M.D., Superintendent County Hospital, Sacramento, Cal.

Read before the California Northern District Medical Society.

The gravity of this disease and the unsatisfactory results of medical treatment place it prominently within the domain of surgery, and it is to the surgeon that the sufferer must look for relief. Pyelitis is an inflammation of the renal mucosa, nephritis, an inflammation of the glandular tissue and pyelo-nephritis, that process involving the entire organ.

The exciting causes of pyelitis are: (1) Diseases of the genito-urinary organs; (a) ascending cystitis; (b) enlarged prostate; (c)

tight strictures. (2) Nephro-lithiasis. (3) Tuberculosis. (4) Traumatism. (5) Cold. (6) Infectious diseases; (*a*) typhoid fever; (*b*) diphtheria; (*c*) pyemia; (*d*) Bright's disease. (7) Irritating drugs, as cantharides, alcohol, turpentine, and ether when used for anesthesia in patients already suffering from kidney disease.

Other things, both real and fancied, have been named as exciting causes, but it may be safely asserted that 90 per cent. of all cases are due to nephro-lithiasis, ascending cystitis, or tuberculosis.

Nephro-lithiasis, or calculous pyelitis, is an organic disease dependent upon a peculiar constitutional diathesis. A few cases originate in causes purely local. Catarrhal or ulcerative conditions of the renal mucosa invite phosphatic deposits around a nucleus composed of small blood clot, mucus, pus, or inflammatory exudate; and thus begins the formation of a phosphatic calculus. Oxalate of lime and uric acid concretions also serve as nuclei for phosphatic stones. Crystallizations of other varieties are dependent upon the component elements of the urine.

These concretions usually pass out of the kidney through the ureter to be voided with the urine. The passage of these stones is attended with agonizing pain (nephralgia), located in the loin along the ureter, or shooting into the testicle. Besides pain, there is often nausea, vomiting, sweating, chill, with scant and bloody urine. These symptoms promptly abate when the stone drops into the bladder.

Lodgment of a stone in any part of the kidney or ureter is most frequently the exciting cause of pyelitis. Second, in frequency, cystitis; and thirdly, tuberculosis.

Calculous pyelitis, in its early stage, is catarrhal, and during this period, except for occasional attacks of nephralgia, is not dangerous to life. When it becomes purulent all the risks attending nephritic or perinephritic abscess are to be anticipated. Sloughs and fibrinous plugs now block the ureter, and hydro-nephrosis is a consequence. The kidney becomes distended by urine and pus; repeated attacks of distension in time results in atrophy and glandular destruction; and the fibrous capsule in an old case is little else than a pus bag.

Tubercular pyelitis begins with nodular deposits in the kidney, which, becoming cheesy and purulent, sooner or later involve the whole organ, the fibrous capsule containing little else than cheesy debris. The bacillus may reach the kidney through any of the following sources¹: (1) By primary infection through the urethra or external genitalia. (2) By the lymphatics. (3) By extension from

¹ Stimson, in Morrow.

a neighboring organ. (4) By way of the blood stream. (5) By inheritance.

The most prominent symptoms in the acute stage of pyelitis are such as indicate visceral inflammation in general—nausea, vomiting, chill, and pain. Pain in the loin increased on pressure, scanty urine, containing increase of mucus, with blood or pus, indicate inflammation of the kidney. As the disease advances the nephralgia diminishes, the urine increases in quantity, becomes cloudy in appearance from the admixture of pus, and is acid in reaction, remaining so for days if left in the vessel. On standing, the pus separates in a greenish-white oily layer and settles to the bottom, leaving the supernatant urine perfectly clear. The quantity of pus voided varies from day to day, ranging from a few drachms to many ounces, the daily variation being due to obstruction of the ureter by renal debris.

Hematuria is a frequent symptom in calculous pyelitis. The blood sometimes coagulates in the ureter when it is passed in long strings. Phosphatic sand is often seen in the urine mixed with pus.

With the progress of the disease the general health deteriorates; the patient has fever, chills, sweats, loses appetite, and becomes thin and cachectic; he develops all, or nearly all, the symptoms of septicemia.

Ascending pyelitis, calculous, and tubercular pyelitis are distinguishable from one another by their clinical history. In the first, there is cystitis or enlarged prostate; in the second, the history of gravel; in the third, a history of tuberculosis in his family, or an affection of other organs of the patient. Finally, the aspirating needle and exploratory incision are not only safe, but certain means of verifying the diagnosis.

The treatment depends upon the individual case and the stage of the disease. In general terms treatment may be divided into: (1) Prophylactic. (2) Medical. (3) Surgical.

Ascending pyelitis is preventable by relieving the cystitis upon which it depends.

Nephro-lithiasis may, and often does, yield to rational treatment. Hyperacidity of the urine is corrected by the administration of alkalis. Concretions are prevented or dissolved by certain salts of potash and lithia, and by the free use of natural mineral waters containing these salts in solution. These waters are of value not only as diuretics, but also for their effect upon the nutritive processes. Malt liquors, dry wines, and the stronger alcoholics must be interdicted. The diet should consist chiefly of milk, eggs, lean meat,

and a limited quantity of farinaceous food. For the relief of pain in all forms of pyelitis, nothing acts so promptly and efficiently as morphine, hypodermically.

Tubercular pyelitis is but little, if at all, influenced by medical treatment. This and chronic lithiasis requires the surgeon's knife. Surgical operations on the kidney may be of all degrees of severity, from acupuncture to nephrectomy.

My own operations, not including punctures made by the aspirating needle, are limited to four cases. The first case was that of a large perinephritic abscess, which ended in a perfect cure. The three others were nephrectomies for profuse pyelitis. Of these, the first and last cases died. They were profoundly septicemic, and were extremely bad cases for a serious operation like nephrectomy. The other and successful case was of shorter duration. Systemic infection was not so profound, the kidney not so thoroughly diseased, and, therefore, reaction from shock was more likely to take place.

CASE I.—M. L——, aged 45; married. First seen in June, 1893, in consultation with Dr. Montague, of Galt. She had then been suffering from pyelitis for more than a year. For several months she had been passing from 2 to 4 ounces of pus daily. She suffered greatly from incontinence of urine, which had excited a painful vaginitis. A tumor over the kidney could be seen as well as felt. She complained of loss of appetite, nausea, vomiting, and occasional attacks of nephralgia. Her most harassing distress was due to the vaginitis. Further examination revealed a nodular ulcer on the posterior lip of the cervix uteri. This was at once removed. With the aspirating needle I drew from the kidney a cylinder full of pus. Unfortunately, the patient was not brought to me for operation until January, 1894, some six months later. She was then profoundly anemic, cachectic, and very thin. With the assistance of Dr. Montague, the operation was easily done, the loss of blood being trifling. The incision was 5 inches long, rather less than 1 inch below the border of the twelfth rib and nearly parallel with it, ranging forward and downward. The erector spinæ muscles were attenuated, the area of renal fat was small; this being stripped off, the vessels and ureter were separated and tied by individual ligatures. The kidney removed, the cavity was flushed and packed with iodoform gauze, and the dressing completed with cotton and an abdominal roller. The after treatment consisted of sustaining measures. Beef tea, milk, whisky, and digitalis were given *per rectum*, and strychnine, morphine, and atropine hypodermically. Despite all efforts to prevent it, she died from shock, 30 hours after operation.

CASE II.—A. C——, an Italian laborer, aged 25. Admitted to the hospital September 29, 1894, to have a vicious union of the femur repaired. At that time he could not speak English, but

through an interpreter it was learned that he came from the lower islands in the Sacramento river, near Rio Vista; that his fractured leg dated from June, 1894, and that for a week or more he had complained of fever, with obscure pain in the back. Little was thought of his back ache, it being masked by more prominent symptoms. His ignorance of the English language prevented him giving a clinical history in detail. His appearance indicated a state of ill health, and no attempt was made to correct the angular deformity of his leg until February 2, 1895. Two months later, in April, he was seized with vomiting and excruciating nephralgia. These symptoms, and an examination of his urine, disclosed the fact that we had a case of pyelitis to deal with. The urgent symptoms subsiding, attention was again directed to the femur, which being slow to reunite, wiring was resorted to on May 5th. A few days later, patient was again seized with vomiting and nephralgia, which most obstinately resisted treatment. For two weeks pain and gastritis demanded large doses of morphine, this affording but temporary relief. Increasing pyuria and failure of treatment prompted me to remove the kidney. The patient's consent was obtained and the operation was performed May 23, 1895. After recovery from shock, his recovery was uneventful. The wound filled in and cicatrization was complete in seven weeks. The kidney is here shown as a wet specimen, and better still, the patient himself is offered in evidence.

CASE III.—A Japanese laborer, aged 25. Admitted to hospital in February, 1895, suffering with ascending cystitis. His back and belly were literally covered with circular scars caused by the cautery, used for his relief by a Japanese doctor. He passed quantities of pus daily, variously estimated at from 3 to 4 ounces. All the symptoms of ascending pyelitis were clearly manifest. Intermittent pain extended from the middle of the back to the middle of the right thigh. There was aggravating cystitis with frequent and painful micturition, and pyuria. Irrigation of the bladder and a variety of medicinal and dietetic treatments were faithfully tried in vain. June 25th, death seemed inevitable, and the nephrectomy was done in hopes of at least relieving him and possibly effecting a cure. The operation was accomplished without difficulty, but, like Case I, death resulted on the second day, from shock.

These two deaths are not without a lesson; they emphasize the importance of early operation.

528 J street.

NEW METHODS OF DEMONSTRATING TUBERCLE BACILLI IN THE SPUTUM.

By ALBERT ABRAMS, M.A., M.D., Professor of Pathology, Cooper Medical College, San Francisco, Cal.

Read before the San Francisco Medico-Chirurgical Society.

Numerous modifications of the original Koch-Ehrlich method of staining the tubercle bacilli have been recommended during the past year. These modifications aim at simplicity and rapidity, though they in no wise detract from the thoroughness of the original

method; in fact, when the demonstration of tubercle bacilli is doubtful, the original method should always be employed.

Among the numerous methods of staining, that of Gabbet suggests itself for simplicity and rapidity. Only two solutions are necessary, and they can be preserved for months. I have employed the Gabbet method for years, and nearly always with satisfactory results. It has occasionally happened that a cover-glass specimen has failed to show the bacilli, whereas another specimen from the same sputum demonstrated the presence of the organisms, when stained according to the Koch-Ehrlich method. The method of Gabbet has been modified by Czaplewski, who employs in place of the methylene blue sulphuric acid solution, a concentrated solution of yellow fluorescein, in alcoholic solution of methylene blue. This modification has for its object the more thorough and certain staining of the tubercle bacilli.

Not only have modified methods of staining been suggested, but also modifications in the preparation of the sputa. The latter change was necessary, in cases where the amount of sputum was limited, or when the tubercle bacilli were few in number. When the bacilli are few in number, the methods suggested for preparing the sputa are directed toward making it homogeneous. The methods of Biedert, Dahlen, and Strohschein are those frequently employed, and are, briefly, as follows:

Method of Biedert: About 15 cm. of sputum is mixed with about 2 tablespoonfuls of water, to which is added 7 or 8 drops of sodium hydrate to each tablespoonful of sputum. The whole is cooked until a thin fluid is obtained; then it is allowed to sediment for two days, although sedimentation is greatly facilitated by centrifugal force.

*Method of Dahlen:*¹ Under this plan sedimentation is more rapid. The sputum, in a vessel, is heated (not boiled) in boiling water. The solid substances, which carry with them the microorganisms, are rapidly precipitated, and can be examined at once for tubercle bacilli.

*Method of Strohschein:*² A certain amount of sputum is shaken in a stoppered bottle, with a solution of borax in water (1:3) until no more coarse particles can be seen; it is then allowed to sediment for 24 to 48 hours, when the precipitate is examined by the conventional method for tubercle bacilli.

Gabritschewsky³ sections the sputum after hardening in alcohol.

¹ München. med. Woch., No. 38, 1891.

² Mitth. aus Dr. Brehm's Heilanstalt f. Lungenkranke.

³ Deutsch. med. Woch. 1891, No. 43.

There are three methods of examination, to which I wish to direct the attention of the Society this evening, which I will call, for convenience of description, the selective, bulk, and digestive methods.

The selective method: In examining the sputa for tubercle bacilli, the essential object to be attained is the selection of the sputa. With the simple apparatus which I here show you, this object can be easily accomplished. It consists of a brass frame, supporting a mirror and a glass vessel, alternately stained black and white. The sputa for examination are thrown into the glass vessel, and after adding a little water to separate the solid particle of the sputum, we now reflect light by means of the mirror on the sputa. Against a black background, we can readily detect small grayish, or greenish gray, purulent masses, which are always characteristic of tuberculous sputa. The purulent masses are removed and thoroughly mixed by a pestle and mortar. From this material, cover-glass specimens can be made. The results with this method are usually excellent.

It is often necessary to prepare many cover-glasses in staining for tubercle bacilli. The inconvenience of handling each cover-glass separately, can be avoided by the apparatus which I here show you. It consists of nine brass frames, each of which is capable of holding 10 cover-glasses. The latter, after being spread with sputum and dried, are introduced into the frames, and the latter are immersed in the staining solutions, contained in large test tubes. Without removing the cover-glasses from the frames, they can be successively introduced into various fluids. The value of this apparatus in expediting work, when a number of examinations must be made, as in hospitals, will be readily seen.

The bulk method: This is only applicable when the sputa are of a semi-solid consistency. It possesses many advantages, chief of which are, dispensing with cover-glass preparations and expeditious work, when a number of specimens from the same sputum are to be examined. Its only disadvantage is, the requisite experience in knowing how to decolorize the specimen. A small quantity of sputum is introduced into a test tube, to which we add a necessary quantity of the Koch-Ehrlich aniline water solution of fuchsin; Ziehl's carbolic fuchsin solution is inapplicable, as it coagulates the sputum and prevents penetration of the staining fluid. The test-tube, containing the sputum, is heated, and the contents of the tube poured on to a finely perforated tin or porcelain strainer. The sputum is now washed by allowing a stream of water to flow on it as it rests on the strainer. It is next introduced into a vessel containing the decolorizing agent and contrast stain; from the latter it is transferred to the strainer and

again washed with water. From the material thus stained, any number of specimens can be made by simply transferring small portions to an object-glass and spreading, by means of a superimposed cover-glass.

The digestive method: This is a substitute for the Biedert method, previously described, to which it is superior in many respects. Digestion is completed in about an hour, and the specimens obtained are in every way superior. The bacilli are better stained, and the undigested portions of the sputa are more defined. The sputum is introduced into a test-tube, to which is added the digesting fluid, composed of a 1 pro mille of hydrochloric acid, containing pepsin. The test-tube is placed in an incubator or a water bath (about 98.6° F.) for an hour; upon removing the tube it is shaken and the contents then allowed to sediment. Before making cover-glass preparations and staining in the usual way, we must render the fluid alkaline by adding a drop or more of caustic potash. Care must be exercised in adding the alkali, as too much of the latter compromises the staining of the tubercle bacilli.

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QUACKS AND HUMBUGS.

By C. H. GIBBONS, M.D., Arbuckle, Cal.

Read before the California Northern District Medical Society.

In the economy of nature all men are required to labor, either with hand or brain, the few exceptions counting no more against the rule than a Coxey's army. In choosing a means of livelihood it is everyone's privilege to follow the advice of the ancient classic: "In whate'er you sweat indulge thy taste." In the diversity of occupations that offer themselves, it is possible for everyone to find a congenial calling. Nor is it often that mistakes occur, for in time all find their proper level—the small potatoes go to the bottom, and if the scum rises to the top for a time it soon disappears.

The majority of men must necessarily engage in one of the three great natural divisions of labor—agriculture, manufactures or commerce. This trinity of intelligence and force supply all the actual needs of mankind. But civilization and refinement create a host of wants, which appear just as important as the needs, and demand each a special class to supply them. Hence the "learned professions," and also the regiments of artists, musicians and actors, and as our *wants* cry louder than our *needs*, so those supplying them assume to stand on a higher platform than those furnishing simply food and raiment.

Now, in order to maintain this exalted station, the professionals must prove themselves worthy the confidence and respect of those they serve. Where little is given little is required, and the morals and manners of the rabble are of less moment to the community at large than the characters of those who have charge of their souls, their bodies, or their purses. Jerusalem was kept clean by every man sweeping his own doorsteps, and it is not our province to discuss the *odium theologicum*, or provoke the terrifying rattle and deadly fangs of our legal neighbors.

No calling is honored and respected more than ours, and this is well, for it is both high and noble. Neither lawyer nor preacher can show such claims to the esteem of their charges, nor do they receive it. No one hears such thanks as the doctor, and his pathway is strewn with the benedictions of those he has befriended. But insects are found in the clearest amber, and the most precious ointment often contains dead flies.

In the medical profession there is a better opportunity to practise rascality with less danger of detection than in any other. The ignorant pretender and the educated charlatan infest every community, and for a limited time practise phlebotomy to the point of syncope on the purses of their victims. When their system of surgery becomes impotent they seek another locality, usually carrying away more money made in a few weeks than the conscientious, painstaking physician has been able to save in a year. Not only this, the "great unwashed" often look upon these shrewd guerillas with awe and admiration, and pity the patient, tireless family doctor, who never boasts of his own cures or parades his name upon a nostrum.

A few years ago one of Sacramento's most honored physicians stopped at a hotel in Lake County. His personal manners won the good will of the mountaineers, and learning his name and occupation, they amazed their less fortunate neighbors by declaring they had talked with the man who made the "liver regulator."

So great is the drain these vampires make upon the coin and credulity of the ignorant that it affects seriously the income and also the standing of many honorable practitioners. Why should you expect to be praised for successfully removing a scrofulous tumor when your itinerant competitor cured forty cases of cancer in one season? Did you watch those cases of scarlatina until the crisis had passed and suppose you would be overwhelmed by the parents' gratitude? Bah! Here is a man who cured sixty-five cases of diphtheria in a month, only three of which had to go to bed at all. Your patients

had kidney trouble after the scarlet fever, and you are accused of causing that by your unskilful treatment. Of course, these stories are too ridiculous for belief, but they do have some effect with the dear public.

True it is, the self-reliant, upright physician seldom notices these unpleasant stumbling blocks in his path. The test of more than a dozen centuries has proved the worth of our system of practice. As a rule its members respect themselves and the profession. But it sometimes occurs that both are so far forgotten that for the sake of a few dollars they fraternize with the most shameless quacks, insult their colleagues, and jeopardize precious lives. Such practices do more harm than flaming advertisements or fakir-vended nostrums, for they bring contempt upon the profession and create a feeling of distrust among its members. If we place ourselves upon a level with those we denounce as humbugs, we need not expect that others will try to raise us. If we trail our credentials of merit in the slime they will remain foul until the next deluge comes to cleanse them.

A CASE OF DIPHTHERIA TREATED WITH ANTITOXIN.

By S. M. MOUSER, M.D., San Francisco, Cal.

Read before the San Francisco Bacteriological Society.

The following case is reported without comment:

June 5, 1895, at 8 P. M., a boy, 3 years old, was brought to my office, who had been dull and feverish during the day. On examination, two greyish-white spots were seen, one on each tonsil. I prescribed quinine, $2\frac{1}{2}$ grs. every three hours, and local applications of liquor ferri subsulph. 3 parts, and glycerine 5 parts.

June 6th, saw patient at 8 A. M. The patches of membrane had disappeared, and the fever was nearly gone. No appetite, and a hoarseness which indicated extension to the larynx. At 10:30 P. M. was called and told the child could not breathe. When I arrived, he had vomited, and was breathing quite easily.

June 7th, 8 A. M. Had a rather restless night, but was free from fever, and took milk freely, though the respiration was somewhat croupy. On applying the brush well down behind the epiglottis, a large piece of membrane was removed, after which he breathed quite naturally. At 4 P. M., croupy respiration again came on, and I asked for a consultation, telling the parents that I had little hopes of his recovery.

Dr. Gross was called, and we decided to use the antidiphtheria serum. Some from the Pasteur Institute, New York, was procured,

and 20 grammes injected beneath the skin of the abdomen, at 5 P. M. Temperature 101.1° , pulse 126, respiration 30. Urine contained a small quantity of albumin. Patient strong and looks bright. 9 P. M., has taken peptone wine and a little milk; sat up in a chair and played with his toys; and is inclined to sleep, though still very hoarse; not able to speak much above a whisper.

June 8th, 8 A. M. Rested rather better during the night. Temperature reduced to 99.5° ; pulse and respiration unchanged. Some swelling on right side of face and neck; not inclined to take nourishment, and has a very offensive discharge from both nostrils, which are frequently irrigated with a 10 per cent. solution of liquor sodæ chlor. 3 P. M. Inclined to sleep constantly, but swallows with less difficulty when roused. Swelling of face and neck about the same. Membrane extending upward, covering the uvula, and a large space of the roof of the mouth, especially on right side, bleeds at slightest touch. Injected 10 grammes of serum.

June 9th, 8 A. M. Has slept, and is sitting up, drinking milk from a tumbler; swallows with less difficulty. Voice better, though still somewhat hoarse. Patches of membrane in roof of mouth and on uvula have been washed away in irrigating. Still slight swelling of neck, but not so much as last night. General appearance better. Increased amount of albumin in urine. 5 P. M. Has taken plenty of milk. Membrane loose and being detached.

June 10th, 8 A. M. Rested pretty well, taking nourishment fairly. Pulse 120, temperature normal. Still hoarse, though cough is softer and less croupy. Membrane still adherent to roof of mouth and uvula, though easily detached by a jet of water from the syringe. Administered 10 c.c.m. of serum. 4 P. M. Has slept most of the time; not inclined to take nourishment. No discharge from nose since morning, though it has bled several times. Ordered irrigations stopped. Have not been able to procure urine for examination, as it has been voided in bed while asleep, and when the bowels moved about noon. Pulse weak and irregular.

June 11th, 8 A. M. Had a very restless night. Coughed, and vomited frequently. Refuses food. Pulse feeble and irregular. Extremities cold. Died at 9 A. M. For 12 hours previous to death there had been no discharge of urine.

705 Bush street.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M.D., Sacramento, Cal., and

WM. FITCH CHENEY, B.A., M.D., Adjunct to the Chair of Obstetrics and Diseases of Women and Children, Cooper Medical College, San Francisco, Cal.

Typhoid Fever in Infants.—DR. W. P. NORTHRUP reports 4 cases of typhoid fever occurring under 2 years of age. One died, and an autopsy confirmed the diagnosis. Dr. Northrup considers the eruption one of the most valuable symptoms toward a diagnosis in infants. He concludes that typhoid fever in infants is rare, and that infection is generally by way of the milk supply. No satisfactory reasons are given for the relative insusceptibility to typhoid at this age, as compared with the other infectious diseases.—*Archives of Pediatrics*, January, 1896.

Infantile Scurvy from Sterilized Milk.—DR. LOUIS STARR says that within 18 months he has seen 5 cases of scurvy in infants, all under 2 years of age. In each of these cases the food was properly proportioned, and had for its basis sound cow's milk, but sterilization had been uniformly employed in its preparation. All recovered rapidly upon the same food unsterilized, with the addition of a small quantity of raw beef juice and orange juice to the diet.—*American Journal of Medical Sciences*, December, 1895.

Germis in Human Milk.—DR. A. JACOBI says that not even the natural food of infants, breast-milk, is free from germs possibly attended with dangers. M. Cohn and H. Neumann found germs in the healthy breast-milk, even after the mamma and nipples had been washed with alcohol and with solutions of corrosive sublimate. A. Palleske met with the staphylococcus pyogenes albus, in one-half of all healthy women; F. Honigmann in most of them, and H. Knochenstein in the mammæ of 8 puerperal and nursing women. Evidently they had immigrated from outside; they proved innocuous. But who can doubt, says Jacobi, but that if the epithelium of the milk ducts had been morbid, there would have been a chance for mastitis, or if the staphylococcic milk had got into contact with a sour stomach or intestine, there would have been an opportunity for gastritis or enteritis.—*Pediatrics*, January 1, 1896.

Tetanus of the Newborn.—In a review of this subject, DR. J. LEWIS SMITH says the prognosis is not so bad as formerly thought. Eight cases recovered out of the 40 he collected. The disease is now known to be caused by the entrance into the system of a rod-shaped bacillus, with one end somewhat rounded like the head of a pin. This bacillus thrives best in dirt and filth, particularly in the soil about horse stables. It has remarkable vitality and power for propagation. It gets into the system of the newborn through the umbilical blood vessels and lymphatics, and there develops a toxin that causes the muscular contractions. Prevention of the disease, therefore, depends mainly on asepsis of the umbilicus and stump of the cord. After the symptoms have shown themselves, the proper treatment is the application of antiseptics to the umbilicus and the administration of chloral, 1 or 2 grains by mouth, or 2 or 4 grains by rectum, every 2 hours. Like diphtheria, tetanus now has a blood serum prepared from the horse, containing the tetanus antitoxin, but this method of treatment is still in the experimental stage. The antitoxin of tetanus is known as Tizzoni's.—*Archives of Pediatrics*, December, 1895.

Acute Rheumatism in Children.—In a recent discussion before the British Medical Association, DR. W. B. CHEADLE expressed the opinion that rheumatism is a general disease; but while in adults the most striking sign of this disease is arthritis, in children this sign occupies a much less important place. Amongst rheumatic diseases he included endocarditis and pericarditis, chorea, purpura rheumatica, subcutaneous nodules, and the exudative erythemata. Chorea and endocarditis were sometimes found in association with scarlet fever, but even in such cases he believed that there was a rheumatic basis. There was probably some morbid agent at work in the production of rheumatism, and he was inclined to anticipate that this would prove to be a specific microorganism, somewhat analagous to that of pneumonia or tubercle.—*Pediatrics*, January 1, 1896.

Dry Dressings for the Navel Cord.—DR. E. A. TUCKER says he has seen several cases illustrative of the remarkable fact that pathogenic bacteria entering by the umbilicus may pass over certain viscera and ultimately find a lodgment in some remote part, as in the meninges. The only effective treatment for these infections in the new-born is a prophylactic one, and this consists in carefully dressing the umbilicus with a dry, clean powder. DR. J. H. FRUIT-NIGHT said in the same discussion that in the earlier years of his practice, when moist dressings for the cord had been in vogue, he had seen suppuration of the umbilicus much more frequently than since he had adopted the practice of using dry dressings. Several other speakers expressed similar views regarding the efficacy of this treatment of the navel.—*Pediatrics*, January 1, 1896. [It has been my practice for some time past to dress the navel of the new-born with dry powdered boracic acid, using it freely both on the stump and on the cotton pad covering it. The results are very satisfactory.—W. F. C.]

Intrauterine Injections of Glycerine.—This was the plan proposed by PELZER some three years ago for the induction of labor. Soon afterward PFAUNSTIEL, a German colleague of Pelzer's, announced that in two cases where he had tried the method he observed the most positive signs of the poisonous effects of glycerine upon the kidneys and upon the blood. Since then other similar effects have been reported, until now DR. B. M. HYPES, of St. Louis, claims that Pelzer's plan should be abandoned. The glycerine is absorbed from the uterus, and getting into the blood causes decomposition of the red blood corpuscles; and the hemoglobinuria thus set up brings on a glomerulo-nephritis, with bloody urine. Dr. Hypes concludes that intrauterine injections of glycerine are often inefficient anyway; that they are apt to be followed by all the ill effects—shock, air, embolism, thrombosis, metritis, and sepsis—of other intrauterine douches which have been used and abandoned during the present century; and that they may, and sometimes do, produce poisonous effects on blood and kidneys.—*American Journal of Obstetrics*, December, 1895.

A New Postural Method for Treating Prolapse of Umbilical Cord.—DR. A. BROTHERS, of New York, proposes the Trendelenberg posture for replacing a prolapsed umbilical cord. This can be readily improvised by placing an ordinary chair upside down at the foot of the bed, the back of the chair making an incline for the legs and hips to rest upon. Dr. Brothers has tried the plan in three cases of prolapse of the cord, each time with success. He found version much easier also with the woman in such position. His cases are reported at length in the *American Journal of Obstetrics*, December, 1895.

SURGERY AND ANATOMY.

By I. W. HUNTINGTON, B.A., M.D., Surgeon Southern Pacific Company's Hospital Sacramento, Cal., and

GEO. B. SOMERS, M. D., San Francisco, Cal.

Position of the Kidney.—In an article on the operative surgery of the kidney, DR. GUITÉRAS, of New York, writes: "My method of locating the organ is as follows: The right organ is $\frac{1}{2}$ to $\frac{3}{4}$ of an inch lower than the left, and its lower border is on a level with the umbilicus. A horizontal line drawn around the body at the level of the umbilicus would, therefore, locate its lower border anteriorly, posteriorly, and laterally. As the kidney is $4\frac{1}{2}$ inches long and $2\frac{1}{2}$ inches wide, and its hilum is usually 2 inches from the linea alba, the outer border would be $4\frac{1}{2}$ inches from the median line, were it not that the kidney inclines backward as well as outward, which would cut down this measurement somewhat. Again, if it is measured upward $4\frac{1}{2}$ inches, (the length of the kidney) from the horizontal line, at a distance of from 2 to $4\frac{1}{2}$ inches from the linea alba, the upper end of the organ would be found to extend well up under the ribs, forming the boundaries of the subcostal angle. It would thus seem that about $\frac{2}{3}$ of the kidney on the right side is behind the liver, whereas fully $\frac{1}{4}$ of the organ on the left side, is behind the stomach."—*Virginia Medical Monthly*, October, 1895.

The Mucous Membrane of the Rectum.—In an article criticising Whitehead's operation for piles, DR. EDMUND ANDREWS says: "A description of the peculiar mechanism and important functions of the mucous membrane and submucous tissue of the rectum will show that we are not dealing with a simple, smooth, mechanical tube, but a highly specialized organ, which cannot be dissected out and destroyed without doing great and irreparable mischief to the patient. The mucous membrane of the lower inch of the rectum has a peculiar mechanism, constituting it a tactile organ, which is the seat of a very acute special sense, by which a healthy person is warned of the presence and downward progress of the fecal mass. Its nerves also possess remarkable reflex powers over the sphincter muscles, so that they resist the sudden and unexpected escape of feces and flatus, without the necessity of a constant mental attention and exertion of the will."—*Mathews' Medical Quarterly*, October, 1895.

Length of Small Intestines.—DR. BYRON ROBINSON obtained the following results in measuring the intestines of 87 males and 26 females. The intestines were measured without being removed from the body. One foot was allowed in every body for the duodenum. The average length of the 113 adult, male and female cases, was exactly 21 feet. The longest small intestine measured 33 feet, the shortest was 11 feet. The highest variation was 22 feet, a variation equal to a normal intestine. In 87 males the average length of the intestine was 23 feet and three inches. The longest was 33 and the shortest 12 feet 6 inches. In the 26 females, the average length of the small intestine was 18 feet. The longest was 29 feet and the shortest 11 feet. These cases revealed that the male small intestine was 5 feet 3 inches longer than the female. The report would be in accord with the size and weight of the male and female body.—*Mathews' Medical Quarterly*, October, 1895.

Intestinal Anastomosis.—In an article with the above title, SCHACHNER closes with the following propositions: (1) The highest degree of vascularity

in the intestine is in the region of the mesenteric border, and the lowest degree is at a point just opposite the mesenteric border. (2) The highest degree of vascularity in the stomach is along its curvatures, and the lowest degree is at a point midway between its curvatures. Throughout the entire intestinal tract there is an absence of the serous coat at the mesenteric border. (3) In view of the diminished vascularity and the constant presence of the serosa at a point midway between the curvatures in the stomach and opposite the mesenteric border in the intestines, these regions should be regarded as *the lines of safety*, and when permissible, should always be given the preference in all operative measures. (4) The dangers of sepsis, hemorrhage, peritonitis, and non-union, increase in direct ratio as we recede from the lines of safety. (5) The strength of a continued or glover's suture is measured practically by its weakest stitch; if this tears, the remaining stitches are all more or less loosened, and the end nearly always defeated. (6) Barring certain exceptions, the continued or glover's stitch is the most rapid, most uncertain, and most uneven stitch that can be applied. (7) No method of intestinal resection, however simple it may be, will receive full justice in the hands of even the most ingenious surgeon, at its first performance. For this reason it should be the duty of all those expecting to engage in such work to thoroughly train themselves in intestinal operations in a practical way, either on lower animals or upon the dead subject. (8) The end-to-end method of restoring the continuity of the intestine in resections, is attended with the least contraction and affords the most natural restoration of the intestinal canal. (9) The opening in all lateral anastomoses should be abundantly large (4 inches) to allow for subsequent contraction, which always takes place to a considerable degree."—*Mathews' Medical Quarterly*, October, 1895.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

By WM. ELLERY BRIGGS, M.D., Sacramento, Cal.

Curettage in the Treatment of Trachoma.—DR. A. N. STROUSE advocates supple curetting of the granular surfaces of the lids for trachoma. He first everts the lower lid and scrapes the trachomatous tissue with a sharp curette shaped like a cataract spoon. Then the upper lid is everted and the curette is carried well up into the fornix, care being taken to scrape the whole of the conjunctival sac, then the everted portion of the lid is treated last. An assistant mops the lids with an antiseptic solution (a saturated solution of boracic acid, or a 1:10,000 bichloride). When the lids are thoroughly cleansed they are touched with a 2 per cent. nitrate of silver solution. The after-treatment consists in the application of the ice pad one-half to one hour. Every other day the lids are touched up with the silver solution, or a stick of sulphate of copper is used after a few days. If the lids are not quite well at the end of two weeks, any granulations that can be found are again curetted, and similar treatment again instituted. The advantages of curettage are as follows: (1) Its uncomplicated *technique* and the rapidity with which it can be performed. (2) Its comparative freedom from pain, enabling us to dispense with general anesthesia. (3) The minimum injury inflicted upon the conjunctival and subjacent tissue. (4) The absence of inflammatory reaction after operation, thus permitting the patient to follow his usual occupation without discomfort. (5) The simplicity of the after-treatment. (6) The radical character of the operation, recurrences being rarely observed.—*Medical News*, January 11, 1896.

Headache Due to Adenoid Growths.—DR. HOWARD S. STRAIGHT reports a case of headache of three years' duration that was cured by removing a moderate amount of adenoid vegetations from the vault of the naso-pharynx. The patient usually awoke with a severe headache, which often prevented his eating breakfast, and he would frequently vomit. About the middle of the forenoon the pain would begin to abate and by noon would disappear. Internal remedies did not relieve him. He complained of nasal catarrh, and an examination of the upper air passages revealed adenoid growths. They were scraped out with a Gottstein curette. The headache ceased at once, and has not since returned.—*Medical News*, November 9, 1895.

The Treatment of Nerve Deafness.—DR. DUNDAS GRANT, in discussing the treatment of nerve deafness, says that nothing like certainty in the treatment can be attained without greater accuracy in the diagnosis of the different forms of disease to which the term is applied. The means of treatment at our disposal include the application of cold by the ice bag, or Leiter's coil; the application of heat—of some value as a local sedative, but in general to be avoided as tending to lower the vasomotor tone; local depletion, by means of living or artificial leeches on the mastoid vein, or of free puncture of the turbinated bodies. Derivation to the intestines is an old and valuable method of treatment in all cerebral congestions or inflammations. When the labyrinth is the seat of invasion, traditional as well as modern scientific therapeutics would indicate the free administration of purgative doses of calomel. The skin should be set in action by heat or sudorifics. Pilocarpine combines with its action upon the skin a stimulation of the absorbent system. To be of value pilocarpine must be used early, before the effusion has become organized. In anemia of the labyrinth it is absolutely contraindicated; in congestion it is advisable, in hemorrhage indispensable. In acquired syphilis it is, within a year of the primary inoculation, to be employed with mercurial treatment, with reasonable prospect of recovery; but in advanced tertiary cases, although rather unpromising, pilocarpine should be used alone before beginning other treatment. If benefit is not produced within a fortnight the drug should be laid aside. In hereditary syphilis of the labyrinth it is occasionally of use on recent cases. The author formulated the following propositions as important: (1) The necessity of careful diagnosis of the different conditions giving rise to so-called nerve deafness. (2) The great value of treatment by means of pilocarpine in fresh exudations into the labyrinth; its comparative uselessness in old standing changes in the labyrinth; its action when at the moment beneficial being usually only transitory. (3) The recognition of the functional character of many cases of nerve deafness. (4) The recognition of the changes in the auditory faculty produced by senility and the avoidance of error in prognosis and of too energetic treatment. (5) The recognition of the frequency of middle-ear disease as a cause of Ménière's symptoms. (6) The hopeful use of galvanism in functional nerve deafness, and even in pure nerve deafness produced by habitual exposure to noises in subjects who are not highly nervous.—*British Medical Journal*, November 26, 1895.

Latent Astigmatism.—DR. HORACE M. STARCEY believes that latent astigmatism plays a more important role in the production of asthenopia than is usually supposed. Since he has adopted the practice of giving patients glasses correcting the apparent error, to be worn continuously for one or more days, after which another test of the refraction is made, the conviction has grown

that latent astigmatism is the cause of much asthenopia. For the benefit of patients whose occupation will not allow them to have their eyes put under the influence of a cycloplegic, a number of spectacle frames provided with cylinders, prisms, and spheres, that can be rotated in any desired direction, should be provided. While not being an ideal method, it has its advantages, among which is the fact that it keeps the patient comfortable from the first. The author relates a number of illustrative cases and enumerates his experience as follows: (1) Latent astigmatism is a frequent and important cause of asthenopia. (2) The latent astigmatism may, in many cases, be made manifest without a cycloplegic and without interfering with the patient's business, by giving lenses which correct the manifest error, which may be worn a day or two, when an additional amount of astigmatism will be manifested, which may be corrected in the same way, and so on until all the latent trouble is unmasked. (3) This can be done without discomfort to the patient, and, therefore, is advantageous with the sceptical, irritable, and nervous. (4) Recent text-books do not give this subject the attention its importance deserves. (5) Astigmatism may be latent whether the axis of the greatest curvature is vertical, horizontal, or diagonal.—*Journal American Medical Association*, November 16, 1895.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. SIMMONS, JR., M.D., Sacramento, Cal.

Congenital Syphilis.—DR. STOPFORD TAYLOR reports a case of congenital syphilis, in a man aged 24 years. It began about four years ago as a sore on the upper lip, and this, slowly spreading, involved both cheeks, the left eyelid, the left side of the scalp, and the alveolus of the upper jaw; the nose, also, was completely destroyed. His present condition was best described as syphilitic lupus.—*Lancet*, October 26, 1895.

Tertiary Blood Serum in Primary Syphilis.—VIEVIOROWSKI, of Moscow, has made some experiments on the treatment of primary syphilis by means of blood serum from individuals affected with gummata or other tertiary forms. He was careful to select for his serum-giving subjects, three persons of ages between 25 and 40, in whom the disease had run a favorable course. The blood was obtained from the median basilic vein, and was received into a vessel, into which had already been placed some solution of common salt of the strength of 20 per cent. and equal in quantity to $\frac{1}{200}$ part of the volume of the blood to be drawn. From this mixture the serum was prepared, and examined in chemical and bacteriological laboratories, none being used until it had been proved capable of standing in a thermostat at 37.5° C. for several days without any developing mould. It was preserved in the dark and in a cool place. Five persons were experimented upon, all of whom had either hard chancres or syphilitic rash and sore throat, no other treatment being or having been employed. The serum was injected by means of a sterilized syringe with an asbestos plunger, into the cellular tissue below the angle of the scapula, the mean dose being 10 cubic centimeters, and the skin being first carefully cleansed by means of ether, spirit, and carbolic acid. The injections were repeated every alternate day, and gave rise to scarcely any local disturbance. Under this treatment, the patients rapidly improved, feeling better and being free from pain, sleeping well and increasing in weight. The physical signs of the disease, too, showed that a good effect had been produced upon it, the chancres

healing very quickly and the rash becoming less distinct. More than 20 injections were given in each case. They did not, however, appear to have much effect in preventing secondary symptoms, so that Vievirowski is far from professing to have discovered a perfect treatment for syphilis. He thinks, however, that he has shown that the serum of the blood of persons with tertiary syphilis has some beneficial effect on primary manifestations. His observations, though hardly likely to be repeated in this country, have a certain theoretical value. He proposes to carry out further researches on the subject, and will doubtless find some of his own countrymen to repeat them. They are, in fact, a continuation of previous observations, published by Prof. Pellizzari, of Florence, and M. Gilbert, of Paris.—*Lancet*, October 26, 1895.

A Case of Dislocation of the Testicle.—DR. RAMON GUITÉRAS reports a case of this accident to the New York Academy of Medicine, November 12, 1895. The patient had been run over by a cart, the wheel passing up between the thighs and over the left pubis and scrotum, left side of the abdomen, and off his body, after fracturing two ribs in the axillary line. An ambulance was sent for and he was taken to the hospital, where his ribs were attended to and he was put to bed. Shortly afterward, discoloration over the left side of the thigh and scrotum was noticed, and an ice bag was applied. The patient remained in the hospital about three weeks, and after leaving observed that his scrotum did not look normal. Dr. Guitéras found a dislocation of the testicle, the organ having been torn from the epididymis, forced through the parietal layer of the tunica vaginalis and up alongside the penis, between the glans and the base. As he could not reduce it, he made two incisions, one over the testicle at the side of the penis, another in the scrotum over the globus major of the epididymis, and replaced the organ. The case had done well.—*Journal Cutaneous and Genito-Urinary Diseases*, January, 1896.

Blenorrhagic Arthritis in a New-born Infant.—HANSBOLTER (*Révue Mens. des Mal. de l'Enfance*) adds a new case to the few already reported in which arthritis was associated with a purulent ophthalmia in a new-born child. The right knee and left wrist were the joints involved; the knee was more severely affected and was the seat of an abundant effusion, which contained polynuclear leucocytes, and showed the presence of the gonococcus. According to the author, this is the eleventh case of the kind reported. Vignandon, in a paper written before January, 1894, gives the notes of 12 cases following ophthalmia, collected from the literature, and 11 cases following vulvo-vaginitis, including 2 observations of his own. A study of the cases shows that there is no connection between the development of the orthopathy and the abundance of the ocular suppuration. In the great majority of cases, gonorrheal rheumatism in the new-born is mono-articular or oligo-articular—the knee is almost constantly involved, much more frequently than with older children and adults. The general condition is little affected, and fever is habitually absent. The duration is scarcely more than a month, and cure results without deformity.—*American Journal of Medical Sciences*, January, 1896.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Typhoid Antitoxin.—BEUMER and PEIPER had already shown the reaction of the human organism to the subcutaneous injection of broth cultures of typhoid bacilli, sterilized by heating to 55° or 60° C. It consists in a slight

febrile condition with transient enlargement of the spleen. In patients with typhoid fever, small doses (at most 0.05 c.cm.) of such a culture, show a marked influence upon the course of the disease. In 8 cases treated in this way, after a few injections, the further progress of the disease was cut short and the fever completely subsided. The authors then instituted a series of experiments on animals, to see whether an antitoxin could be obtained similar to those of diphtheria and tetanus. By injecting sheep for three months with broth cultures of the typhoid bacillus, they obtained serum which had marked antitoxic properties, though it had no direct power of destroying the bacillus. The serum has curative powers, since of 5 guinea pigs treated one hour after injection, none died; of 5 treated two hours after injection, 2 died; of 5 treated three hours after injection, 3 died; and of 5 treated four hours after injection, 1 died. As a rule, animals die from 12 to 24 hours after a fatal dose of typho-toxin has been injected. In every case, animals treated with typho-toxin for a long time, yielded a serum which had immunizing and curative powers. How far these results may be applied to patients, one cannot as yet say with certainty. The harmlessness of the serum to human beings has already been proved.—*British Medical Journal*, November 2, 1895.

Diuretic Action of the Lithium Salts.—Lithium carbonate is almost an insoluble body, and consequently should be given in carbonic acid water, whereby it is converted into a soluble bicarbonate. When administered alone, it is changed by the action of the hydrochloric acid in the stomach into a chloride, which can only be absorbed to a limited extent; thus it is not the action of the carbonate, but of the chloride, that has to be reckoned with. Of all the lithium salts, the chloride is the least able to combine with uric acid, and to produce a soluble salt which may lead to the elimination of uric acid. It is admitted that the treatment which aims at bringing about a solution with the elimination of the uric acid deposited in the tissues, is not altogether satisfactory. It would appear that the increased diuresis has much to do with the benefit obtained in these cases. Mendelsohn, by a series of experiments on animals, has established the diuretic action of the lithium salts, the citrate being found to be the active one.—*British Medical Journal*, November 16, 1895.

Serum Treatment of Phthisis.—The communication made by PROF. E. MARAGLIANO, of Genoa, to the British Medical Association, in London, and to the Medical Congress, at Bordeaux, on the serum treatment of tuberculosis, is of great interest. After three years of investigation, Prof. Maragliano succeeded in preparing a serum which he believes to contain the antitoxins of tuberculosis, and which he has now employed with apparent success in the treatment of phthisis. The serum has been obtained from dogs which have been immunized by successive vaccination with tuberculous material derived from human subjects. The most noticeable effects of injection of this serum in human subjects are: (1) A temporary elevation of temperature from a large dose. (2) An increase in the leucocytes in the blood. From an experience of 83 cases, representing all the forms of pulmonary tuberculosis, from the most severe to the mildest, Prof. Maragliano deduces the following conclusions: (1) Cases with circumscribed foci of disease, with little or no fever, and free from the association of active microbes, show marked improvement. Forty-five such cases have been treated, and of these, all who have undergone methodical and complete treatment (29 cases) could be considered as cured. The

remaining 16 cases, some of which were febrile, improved considerably, but have not completed the treatment. (2) Cases of tuberculous broncho-pneumonia, with diffuse centers of disease, febrile or apyretic, but with few associated microbes, give hopes of cure if the treatment is persevered with; 14 such cases have all improved under treatment. (3) Diffuse broncho-pneumonias, with association of microbes, show less marked improvement; 14 such cases have been under treatment, and their condition has remained almost stationary. (4) Destructive broncho-pneumonias, with cavities, show only slight improvement; out of 9 cases, 3 febrile cases improved considerably for a time, becoming free from fever and gaining weight. One of these, having given up the treatment, died a year later, and 1 is still under treatment. Of the other cases, 4 remained stationary and 2 are dead. The treatment must be continued for a long time to bring about a cure, otherwise relapses are liable to occur. Some cases have been two years under treatment. As to the mode of using the serum, Prof. Maragliano commences in apyretic cases with a dose of 1 c.cm. every second day for 10 days, then a similar dose every day for another 10 days, then for the next 10 days two similar injections each day. With slight fever, the same procedure may be followed; but with high temperature, an attempt should be made to control the fever with large doses, and 10 c.cm. of serum may be injected at one dose. The treatment should be continued for a month, at least, after the cure seems to be accomplished, and it may be advisable to continue with weekly injections of 1 c.cm. for a year. There are not any contraindications to the use of the serum.—*Practitioner*, October, 1895.

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

Polyn neuritis in Mercurial Intoxication.—Medical literature of late abounds in the citation of cases of multiple neuritis following the use of mercury. One of the latest contributions to the subject is made by MM. SPILLMANN and ETIENNE, of Nancy. The three following cases are reported: *Case I.*—A boy, cooper by profession, who was treated for blenorrhagic epididymitis by means of a syrup and pills containing mercury. Soon after pains occurred in the limbs, with muscular atrophy and paresis. These accidents slowly retroceded, and the malady was cured in about 2½ months. *Case II* was that of a commercial traveller treated for a chancre. Mercury employed in this individual was followed by intense symptoms of mercurial intoxication, consisting of disturbances of phonation and deglutition, disturbances of the psychical state, pains in the extremities and muscular atrophy. *Case III.*—After mercurial treatment the following symptoms occurred: Fever, stomatitis, diarrhea, albumin in the urine, pains in the extremities, accompanied by diminution of the patellar reflex. Cessation of treatment in this case was followed by cure. It was experimentally demonstrated that similar symptoms follow the administration of mercury to rabbits. The authors admit that polyn neuritis of mercurial origin occurs in individuals predisposed to nervous affections, and in others who react idiosyncratically to mercury.—*Sémaine Médicale*.

The Cure of Aortic Insufficiency.—PICOT reports two cases of cure of this affection. In one case, a male, aged 30 years, addicted to alcohol, with dilatation of the aorta and insufficiency of the aortic semilunar valves; there was also present considerable hypertrophy of the left ventricle of the heart. To this patient iodide of potash was given in doses varying from 1½ to 2 grammes

a day. At first the administration of the drug proved inefficacious, but on continuing its use the symptoms of the valvular lesion completely disappeared, after an interval of $2\frac{1}{2}$ years. In the other case, there was an aneurism of the aortic arch, with pronounced manifestations of aortic regurgitation. To this case iodide of potash was given, with the result that, in about 8 months, the phenomena of the valvular lesion retroceded. "These observations," so the author concludes, "permit one to hope that under the influence of the iodide of potash and the suppression of alcohol, the cure of aortic affections may be realized."—*Semaine Médicale*. [The author, in his deductions, has not taken syphilis into account as an etiological factor. Syphilitic inflammations of the aorta are relatively frequent, either manifested as a chronic endarteritis or as a diffuse gummatous inflammation of the media and adventitia. Döhle (*Deutsch. Archiv. für Klinisch.*, Bd. 55), refers to the frequency of syphilitic aortic affections. Macroscopically, syphilitic aortitis is characterized by radiated cicatrices and depressions appearing on the inner coat of the aorta.—A. A.]

The Diagnosis of Carcinoma of the Pancreas.—V. ENGEL reports (*Präger med. Woch.*), four cases of this affection, in two of which the diagnosis was made *intra vitam*, and corroborated by the *post-mortem* examination. A constant initial symptom is epigastric pain. Vomiting is usually absent, and the appetite is in no wise disturbed, a point of some value in differentiating carcinoma of the pancreas and stomach. Icterus is usually present; enlargement of the gall bladder was not noted by the author. Ascites and compression phenomena of the large abdominal vessels were not manifestly present, notwithstanding the fact that the tumor in three cases was of large size; a fact of importance in the differentiation of hepatic disease. Glycosuria was not present in any of the cases, nor was there large quantities of fat in the feces. In one case, however, the administration of 200 grammes of cane sugar was followed by alimentary glycosuria. In the same case, the injection of 50 grammes of olive oil was followed by a large quantity of fat in the feces. The foregoing symptoms, with the demonstration of an epigastric tumor with manifest cachexia, permit of the diagnosis, carcinoma of the pancreas; without the demonstration of the tumor no certain diagnosis is possible.—*Centralblatt f. Innere Medicin*.

GUTHRIE RANKIN remarks that in recorded observations of pancreatic lesions, it would seem that primary disease is the exception rather than the rule, and that when the pancreas is attacked its implication is usually secondary to preëxisting disease in the stomach, duodenum, liver, or gall bladder. The leading symptoms in two cases reported by him were great emaciation, excessive weakness, paroxysmal pain, and in the later stages of the illness deep seated epigastric tenderness. While so much stress has been laid on the presence of fat in the alvine evacuations as characteristic of pancreatic disease, his two cases show that even in advanced conditions of structural disease of the pancreas, that symptom may be entirely wanting. If to the above symptoms are added nervous disturbance, which can be referred to the vagus or sympathetic, the probability of the pancreas being the *fons et origo mali*, is strengthened; and if further corroborative testimony is afforded by a hard mass in the epigastrium, by glycosuria, by persistent jaundice without liver symptoms, by stools, which are greasy in appearance, or clay-colored without an obstructed bile duct to be found in explanation, then the diagnosis may be looked upon as practically certain, while the prognosis, unfortunately, is absolutely hopeless.—*British Medical Journal*.

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. HOISHOLT, M.D., Assistant Physician, State Asylum for Insane,
Stockton, Cal.

Pathology of Idiocy.—In an article on mental enfeeblement and idiocy in children, DR. F. SAVARY PEARCE, of Philadelphia, treats of the pathology of idiocy. He mentions that in the local or general atrophy of the brain met with, the nerve-cells are round instead of stellate, and are not branched. In the white matter few nerve-fibers exist as compared with the excess of neuroglia or connective-tissue elements. Atrophy of the anterior cornua of the cord has been observed, but no degeneration in its white columns has been noted. Hypertrophy, which may be general or partial, is seldom seen and must be distinguished from hydrocephalus, which breaks down and becomes the granular-looking debris described by Rokitansky. Softening due to insufficient blood-supply is frequently observed, and may be local or general; it may be caused by meningitis, tumors, thrombi of the middle cerebral arteries, or of the superior longitudinal sinus. Microscopically, remnants of nerve-fibers, granular cells, debris, and blood-corpuscles are seen throughout the field. Sclerosis may be diffused in spots; the medullary substance is usually increased, as compared with the gray matter. Hydrocephalus is seen in not a few idiots, and it is in these cases that the extremities are frequently paralyzed from excessive cerebral pressure. Porencephalus is either the result of diffuse hemorrhage *in utero*, or is due to trauma later in life. Tumors may occur and are either tuberculous or gliomatous. Asymmetry of the head and of the convolutions is sometimes found. Simplicity of the convolutions in size and arrangement is often seen, and is an evidence of reversion to our arboreal ancestry. Chronic meningitis is frequently present, and acute meningitis, the simple or tuberculous form, is often the cause of death. The most frequent lesions of the cerebellum are atrophy, tuberculous tumors, and cysts. Descending degenerations in the spinal cord are found where cerebral palsies coëxist with imbecility. The most common physical signs of degeneracy are high palatal arches, badly set teeth, and club-foot. The latter is more common in males. The round ganglion-cells are seen to have a clear space or faintly-stained granular substance around a round or oval nucleus placed in the center of the cell; the clear space being due to a retraction of the protoplasm. With the exception of the axillary pole, the cell-processes are small and stunted. The nucleus stains deeply, the protoplasm less so. In frozen as well as in hardened sections of the cortex, not more than five layers may be detected; the third layer is most affected.—*International Medical Magazine*, October, 1895.

Two Cases of Raynaud's Disease.—DR. A. R. URQUHART reports 2 cases of this disease, observed by him in the Royal Asylum, at Perth, Scotland. They were cases of spontaneous symmetrical gangrene of the toes, in a man, aged 33 years, who was suffering from a psychosis, with marked illusions and hypochondrical ideas; and in a woman, aged 50 years, presenting symptoms of melancholia atonita. In the latter case, extreme motor excitation, marked trophic disturbances and hematoma auris were present, and the symptoms of Raynaud's disease subsided with the disappearance of the local asphyxia. In the first case, bilateral othematoma was present, and the case terminated fatally on the third day after the beginning of the vaso-constrictor symptoms. The *post-mortem* examination showed, besides old tuberculous changes in the lungs and left kidney, an atrophy of the brain, with dilatation of the ventricles, and cloudiness of the arachnoid. Microscopically there was no inflamma-

tory or degenerative processes in the pons and medulla, no neuritis of the anterior or posterior tibial nerve, nor endarteritis in the anterior tibial artery; not even in the region of the gangrene were any changes observed in the nerves or vessels, with the exception of an enormous dilatation of all the vessels, probably due to the vasomotor paralysis. But little extravasation of blood had taken place; the other tissues showed degenerative, *i. e.*, microbic changes. In the discussion which followed the reading of the paper, in the Medico-Chirurgical Society of Edinburgh, it was observed by Cathcart, that gangrene in the foot may be caused by a vascular obstruction at the bifurcation of the popliteal artery, and Clouston mentioned that he had only observed Raynaud's disease in the course of acute psychoses, especially of acute mania, in which motor, sensory, and trophic disturbances are never absent. He directed attention to the great difficulty encountered in certain cases of psychic affection, of keeping the extreme parts of the body warm, which he considers a symptom allied to those observed in Raynaud's disease. The complication of hematoma auris observed in these cases, Clouston considered of great importance.—*Edinburgh Medical Journal—Centralblatt f. Innere Medicin.*

Insanity Cured by Removal of a Fibroid Tumor of the Ovary.—DR. EMORY LANPHEAR reports the following case: A patient, aged 36, was married at 20, and had four children. For several years she had had a slowly growing, small, very hard tumor in the pelvis, which pressed upon the bladder, causing marked vesical irritation. Serious disturbances at the menstrual periods were for more than a year ascribed to irritation set up by the tumor, when finally a typical menstrual (!) mania developed about January, 1891. The maniacal excitement became very severe, and becoming violent she was admitted to a hospital for the insane. A laparotomy was afterwards performed, and a true fibroid of the ovary was removed from the right side. The tumor measured $2\frac{1}{2}$ by 8 inches. Extirpation of the left ovary and tube was at the same time made. At the next menstrual period the mental excitement returned, and lasted four or five days, but with each menstrual period the attacks became milder, until the patient was ready to be discharged after 9 months. She is reported to have remained well during the last three years.—*Southern Medical Record—International Medical Magazine*, September, 1895.

FORMULÆ.

By H. E. SANDERSON, M. D., Assistant Physician State Asylum for Insane, Stockton, Cal.

Herpes Zoster:

Boric acid.....gm. 1
Glycerine q. s.
Vaseline.....gm. 30
Cocaine hydrochlorate.
Extract of opium āā---gm. 0.30

S.—Apply to the affected part.—*College and Clinical Record.*

Hepatic Torpor:

Acid. nitro-hydrochlor. dil.---mx
Tinct. podophyllin. mx
Succ. taraxaci 3i
Tinct. nucis vom. mx
Syr. zingib. 3ss
Aq. menth. pip. q. s. ad. 3ss

S.—In water three times a day.—*Practitioner—Therapeutic Gazette.*

Nutrient Enemata of Emulsified Oil:

Codliver oil.....18oz.
Yolks of two eggs.
Lime water.....18oz.

—*Practitioner.*

Coal Oil.—DR. J. H. POWELL uses the following in local troubles, such as intercostal neuralgia, painful joints, etc.:

Coal oil 3 ii
Spts. turpentine 3 ii
Aq. ammonia 3 i
Tr. opii. 3 i

S.—For local applications.—*Cincinnati Medical Journal.*

Hereditary Syphilis.—For an infant five or six weeks old a solution called Van Swieten's liquid should be used, the composition of which is as follows:

Bichloride of mercury	--gr. ii
Alcohol	----- 3 iii
Water	----- 3 xxix

S.—Twenty drops (in divided doses) during the day. This to be combined with mercurial inunctions.—*Therapeutic Gazette.*

Mercurial Injections.—EICHLER employs the bichloride of mercury in hypodermic injections in the early treatment of syphilis. The solution which he uses is as follows:

Hydrarg. chlor. corrosiv.	---gr. i
Glycerini.	
Aquæ aa	----- 3 i

S.—Inject 10 minims daily for 12 days, then give a week's rest and then 12 more daily injections, and so on.

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., San Francisco, Cal.

Mortality for December, 1895.—The deaths registered in 57 town districts of the State, during the month of December, in a population of 774,870, correspond to an annual rate of 15.96 a thousand, the total mortality having been 1,031. 64 deaths were due to zymotic diseases, giving an annual rate of .98 a thousand. Of these, 9 were due to diphtheria, 8 to cholera infantum, 20 to typhoid fever, 6 to diarrhea and dysentery, 3 to cerebro-spinal fever, 3 to whooping cough, 9 to croup, 6 to intermittent and remittent fevers, 0 to scarlet fever, 0 to measles, and 0 to small-pox. 294 deaths resulted from diseases of the respiratory organs, giving an annual rate of 4.34 a thousand. Of these, 175 were due to consumption, 85 to pneumonia, 25 to bronchitis, and 9 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.64 and 1.30, respectively. 116 deaths resulted from diseases of the heart, 4 from alcoholism, 4 from erysipelas, 42 from cancer, and 439 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 617,000, was 16.08. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from Fresno, the lowest from Berkeley.

METEOROLOGY.

Summary for December.—*Temperature.*—The normal temperature of the State for December is 52.9°; the average for December, 1895, was 46.1°, a departure from normal of -6.8°. The highest monthly mean was 71°, at San Ana; the lowest, 21°, at Bodie, in the mountain regions of Mono county. The maximum temperature was 110° at Salton, on the 12th, in the desert regions of Riverside county. The minimum, 19° below zero, at Adin, Modoc county, on the 22d, and at Bodie, Mono county on the 29th, in the high mountain regions of the State. The greatest monthly range was 92°, at Salton; the least, 18°, at Point Lobos. The absolute range for the State was 129°.

Rainfall.—The normal precipitation for the State for December is 4.42 inches; the average for December, 1895, was 1.95 inches, a departure from the normal of -2.47 inches. The greatest monthly precipitation was 11.20 inches, at Bowman's Dam. The least, nothing, at Barston, McMullen and Needles.

Wind.—The prevailing direction of the wind for December was W.N.W.

Unusual Features.—The unusual phenomenon was the cold spell of the last few days of the month, when the peculiarity of a desert town having a maximum temperature of 110° in the early part of the month and a minimum of 18° during the latter half of the month was recorded.—JAMES A. BARWICK, Director California Weather Service.

California—Tabular Statement for December, 1895.

Departments.

STATIONS.	TEMPERATURE.						RAINFALL.	WEATHER.		WIND.	FURNISHED BY—
	Mean.....	Highest	Lowest.....	Mean High- est.....	Mean Low- est.....	Mean Daily Range		No. of Clear Days.....	No. of Fair Days.....		
							No. of Days Rain Fell.....	Total Rain- fall.....	No. of Cloudy Days.....	Prevail- ing Direc- tion.	
Auburn	47.0	73	25.0	53.0	41.0	12.0	8	3.39	17	N.E.	Southern Pacific Company.
Berkeley	47.0	58	34.0	53.0	41.0	12.0	8	2.20	6	S.E.	Obs. University of California.
Colfax	44.0	70	26.0	53.0	41.0	12.0	8	8.85	6	S.E.	Southern Pacific Company.
Coronado	62.0	88	44.0	73.0	51.0	22.0	2	0.27	24	N.E.	Hotel del Coronado.
Eureka	47.0	67	30.0	54.0	40.0	14.0	19	7.50	8	E.	Weather Bureau Dept. Agr.
Fresno	44.0	71	26.0	51.0	36.0	15.0	4	0.78	10	E.	"
Independence..	38.0	66	16.0	51.0	25.0	26.0	2	0.08	18	N.W.	"
Los Angeles...	56.0	86	34.0	69.0	44.0	25.0	4	0.78	22	N.W.	"
Monterey	53.0	68	28.0	56.0	40.0	16.0	6	1.46	11	S.	Southern Pacific Company.
Napa	48.0	64	32.0	53.0	40.0	13.0	10	1.47	12	N.	Station Napa Insane Asylum.
Oakland	45.0	62	32.0	53.0	40.0	13.0	10	1.74	10	N.W.	Chabot Observatory.
Paso Robles...	42.0	64	20.0	54.0	30.0	24.0	2	0.55	22	S.	Southern Pacific Company.
Red Bluff.....	43.0	61	28.0	51.0	36.0	15.0	8	2.99	13	N.W.	Weather Bureau Dept. Agr.
Sacramento. ...	45.0	65	28.0	52.0	38.0	14.0	8	1.54	9	S.E.	"
San Bernardino	51.0	84	24.0	67.0	35.0	32.0	3	0.66	26	W.	A. K. Johnson, M. D.
San Diego.....	55.0	79	34.0	65.0	45.0	20.0	2	0.27	24	N.E.	Weather Bureau Dept. Agr.
San Francisco..	49.0	60	39.0	54.0	44.0	10.0	9	1.43	15	N.	"
Santa Barbara..	55.0	84	38.0	66.0	44.0	22.0	2	0.93	26	W.	Hugh D. Vail.
Santa Cruz.....	51.0	73	29.0	62.0	40.0	22.0	7	2.15	21	W.S.	W. R. Springer.
Yuma.....A. T.	54.0	80	30.0	66.0	42.0	24.0	0	0.00	28	N.	Weather Bureau Dept. Agr.

Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: FEBRUARY, 1896.

CRIMINAL PRACTICES WITH CHILDREN IN SAN FRANCISCO.

The recent arrest, in San Francisco, of a number of men charged with debauching children, revealed several hot-beds of abominable practices, to which large numbers of children were lured. OFFICER THOMAS ROURKE, who made the first arrest, was detailed for special duty in investigating these cases. From the confessions of the children, he traced 117 girls, who had been in the habit of visiting certain men and resorts. These girls ranged in age from 7 to 14 years. Fourteen of them were arrested and held as witnesses. Of the men, 10 were arrested, though many more were implicated, but were not molested, owing to insufficient evidence. The ages of the men were from 42 to 73. Their nationality and occupations were as follows: Italian, barber; German, cook; French, organ-grinder; Italian, shoemaker; Mexican, barber; Scotch, laborer; Jew, marble dealer; Swede, capitalist; American, newspaper carrier.

All of these cases occurred in the northern portion of the city, near what is known as the "Barbary Coast," which is inhabited principally by the lower classes of Mexicans, Italians, and Portuguese, and which teems with dives and low music halls. The resorts of the children were either the private lodging rooms of men, or rooms in the rear of shops. In one of the latter places, in the rear of a barber shop, every imaginable practice was carried out for the benefit of several men. Obscene pictures and obscene instruments were exhibited to the children, and dreadful orgies were held. OFFICER ROURKE stated that the children were always paid small sums of money for their visits. They were generally enticed by an older girl, who acted as procuress, and who received a fee for each new child obtained.

The first arrest was of two sisters, who were seen walking along the streets at about 3 o'clock in the morning. They were accosted by the officer, but did not give a satisfactory account of themselves.

They were arrested and the next day taken before their parents, who did not seem to know that the children had been away an unusual length of time. The girls finally confessed that they were on their way to the rooms of a man, who had promised to take them to the Golden Gate Park. They had been in the habit of visiting this man early in the morning for some time past. The oldest of these two girls was 14. Their confessions led to the arrest of others.

In many of these cases the parents were ignorant, careless, or indifferent, and wholly to blame for the conduct of the children. In others, and notably in a number of cases where the children were not taken into custody, the parents were well-to-do and intelligent, and the revelations came to them as a terrible shock. In these cases the children were generally led away by companions at school, and the visits were made shortly after school hours.

This condition of things is by no means new. The public hospitals in San Francisco are frequently visited by parents who desire to have their children examined for evidences of criminal assault. In the majority of these cases there is no absolute evidence on the child's person, and not sufficient corroborative testimony to convict the guilty person. An arrest and trial results in more harm than good, for it ends in an acquittal in the great majority of cases from insufficient evidence. It further serves only to corrupt the mind of the child by subjecting her to all sorts of questions and to demands from the attorneys taking her testimony for minute explanations of filthy topics. Every one of these trials should be carefully followed by some humane organization with the object of protecting the children's rights on the witness stand. The scene in the San Francisco Police Courts, where children are being questioned in these trials, is simply shocking. It is true that most of them are held with closed doors, but this does not preclude the presence of from 15 to 20 men.

THE REDUCTION IN THE FEES OF MEDICAL EXAMINERS FOR LIFE INSURANCE.

The reduction in the fees for medical examinations for life insurance inaugurated by the New York Life and the Equitable Life, is already attracting the attention of the profession in a manner that leads us to hope concerted action will be taken, and that a determined and united stand will be made in regard to this outrage. We

are fully cognizant of the difficulties to be encountered in initiating and in maintaining any organized movement in the profession. It is the absence of this cohesion that exposes us to predatory raids from every direction. In the present case, however, the issue seems so perfectly clear, and the alternative of inaction or of submission so inevitable, that we have great hopes of such a showing being made as will compel the offending corporations to withdraw this ill-advised action. This issue, as we have stated it, should not be lost sight of. It is, "Shall medical men render to wealthy corporations precisely similar services at different rates of remuneration, which rates are based upon considerations neither directly nor indirectly pertaining to the labor or to the responsibility involved?" The matter will not be allowed to rest in its present state, and we believe that the companies must reconsider their action, or adopt a method of dealing with the question of medical examinations that is not, at present, in vogue.

As far as we are aware the first Society on this Coast to take up the matter was the Sacramento Society for Medical Improvement. It seems proper that action of this character should be initiated here, as the Society is the oldest medical organization in this western territory. The resolutions presented at the December meeting are clear, concise, and unmistakable in character. They are as follows:

WHEREAS, The New York Life Insurance Company and the Equitable Life Assurance Society have recently adopted a graded scale of fees for medical examinations, the practical effect of which will be a reduction of the Medical Examiner's income from these sources by about 40 per cent.; and whereas, these companies, claiming to be amongst the largest and strongest in the world, have, hitherto, in common with all other first-class "old line" life insurance companies, paid a uniform fee of \$5 for medical examinations, insisting that the same care be used in examining applicants for small as for large policies; and whereas, under the proposed schedule, no reduction is made in the amount of work performed or in the degree of responsibility exacted; therefore, be it

Resolved, That we, as physicians, recognize that all life insurance is based on mortality tables and on the probable life expectancy of the assured, in arriving at which the Medical Examiner is the most important factor, and that in the past he has been the most valuable as well as the most essential feature in the establishment of life insurance companies.

Resolved, That we cannot recognize, as a principle governing our remuneration for exactly similar services, the amount of premium paid by the applicant, or the profit derived by the company from any individual risk.

Resolved, That such methods, having no foundation in reason or justice, are contrary to all business principles, and must inevitably lead to a lower standard of examinations, with correspondingly disastrous results.

Resolved, That the Sacramento Society for Medical Improvement protests against methods that are unfair, irrational, and indefensible, and, on behalf of its members, pledges them to absolutely decline to examine applicants for life insurance for any "old line" company, for any fee less than \$5, for each and every examination made.

Resolved, That copies of these resolutions be transmitted to every medical society in California, to all State medical societies, and to the American Medical Association, requesting that concerted action be taken in the premises.

The discussion on the adoption of the resolutions is instructive, as indicating the drift of professional sentiment and its force. Believing that it is of general interest to the profession, we give it at some length on another page. The resolutions were adopted at the January meeting by a practically unanimous vote, and have been transmitted to the different societies, and to other sources through which medical opinion can be formed and organized.

If the truth were known it is more than probable that many of the insurance companies estimate the value of the medical examination at a comparatively low figure. Some companies have even proposed to abolish medical examinations altogether; but this innovation has not been put in practice. In this connection, we find in the *Medical Examiner* a quotation from the *Insurance Press*, in which MR. R. P. FIELD, Vice-President of the Security Trust Company, of Philadelphia, discusses the question, "Does it all rest on medical selection." According to the *Medical Examiner*, this gentleman says there are many questions in the examination blank which can be intelligently asked and the answers recorded by any well trained insurance man, "upon nothing except the history of previous illness, and the present physical condition of the applicant, is it absolutely necessary for a physician to pass?" Therefore, the purpose of the *Medical Examiner* is to ascertain what the present physical condition of the applicant is, and the possible effect of any previous disorder. We will not pursue this issue further at present, but will reserve its discussion for a future occasion. It is, however, significant as indicating the truth of our position that the grading of fees on the absurd basis suggested emanates really from the actuarial and not from the medical departments of the insurance companies under fire.

In response to an editorial in our issue of January, we have received a number of letters from members of the profession endorsing the position of this journal, and advocating concerted opposition to the raid on their incomes. This response is most gratifying, and it is the basis for our hopes that the profession will really assert itself in this matter. The correspondence is well worth reading, and we shall, in our next issue, publish another installment, as several letters were received too late for publication. Meanwhile we desire to report progress, and to urge upon every medical society and every medical community the necessity of taking immediate action, without waiting to see what any one else will do in the matter. As an example of not waiting for "something to turn up," we commend the course of the physicians of Red Bluff, who have, as DR. JOHN FIFE states in his communication, organized and refused to accept the proposed schedule. We believe that that town will have the honor of being the first in California that has taken formal action in this matter.

NOTES.

California Northern District Medical Society.

The semi-annual meeting of the California Northern District Medical Society will be held at Red Bluff, on March 10th. The following Committee of Arrangements has been appointed: John Fife, Red Bluff, Chairman; J. C. Cameron, Red Bluff, and B. M. Gill, Shasta. In our next issue we shall publish the preliminary programme and other information connected with the meeting.

Nevada State Medical Society.

The semi-annual meeting of the Nevada State Medical Society was held at Virginia City, January 13, 1896. The following officers were elected for the ensuing year: P. T. Phillips, Reno, President; P. Manson, Virginia, Vice President; T. P. McDonald, Virginia, Secretary and Treasurer; H. H. Hogan, Reno, Jas. Guinan, Carson, J. E. Pickard, Virginia, Censors. The annual meeting will be held at Reno, on July 13th.

Dr. H. E. Sanderson.

With this issue, Dr. H. E. Sanderson, of Stockton, will assume charge of the department of Formulæ. Dr. Sanderson is, at present, an Assistant Physician at the State Asylum for Insane at Stockton. During his residence in San Francisco, Dr. Sanderson lectured on Theory and Practice of Medicine at Cooper Medical

College. We therefore feel certain that the Doctor will bring to his work a capacity for it, and a knowledge and appreciation of that which will be most practical and beneficial to the physician in active practice.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, December 17, 1895.

The President, C. B. NICHOLS, M.D., in the Chair.

Reduction in the Fees for Medical Examinations for Life Insurance.—DR. T. W. HUNTINGTON, as Chairman of the Committee to which this matter had been referred, submitted as its report the following preamble and resolutions:

WHEREAS, The New York Life Insurance Company and the Equitable Life Assurance Society have recently adopted a graded scale of fees for medical examinations, the practical effect of which will be a reduction of the Medical Examiner's income from these sources by about 40 per cent.; and whereas, these companies, claiming to be amongst the largest and strongest in the world, have, hitherto, in common with all other first class "old line" life insurance companies, paid a uniform fee of \$5 for medical examinations, insisting that the same care be used in examining applicants for small as for large policies; and whereas, under the proposed schedule, no reduction is made in the amount of work performed or in the degree of responsibility exacted; therefore be it

Resolved, That we, as physicians, recognize that all life insurance is based on mortality tables and on the probable life expectancy of the assured, in arriving at which, the Medical Examiner is the most important factor, and that in the past he has been the most valuable as well as the most essential feature in the establishment of life insurance companies.

Resolved, That we cannot recognize, as a principle governing our remuneration for exactly similar services, the amount of premium paid by the applicant, or the profit derived by the company from any individual risk.

Resolved, That such methods, having no foundation in reason or justice, are contrary to all business principles, and must inevitably lead to a lower standard of examinations, with correspondingly disastrous results.

Resolved, That the Sacramento Society for Medical Improvement protests against methods that are unfair, irrational, and indefensible, and, on behalf of its members, pledges them to absolutely decline to examine applicants for life insurance for any "old line" company, for any fee less than \$5, for each and every examination made.

Resolved, That copies of these resolutions be transmitted to every medical society in California, to all State medical societies, and to the American Medical Association, requesting that concerted action be taken in the premises.

THOS. W. HUNTINGTON, Chairman.

W. J. HANNA,

JAMES H. PARKINSON.

The speaker stated that he regretted exceedingly the absence, through illness, of Dr. Parkinson, a member of the committee.

DR. W. J. HANNA: The resolutions cover the ground fully in every respect. I think the Society should take some action in this matter at the present time. I have had communications from the New York Life Insurance Company for the last two months, in relation to it. I believe that Dr. Parkinson has already made a stand in regard to this matter with reference to the Equitable, and that he proposes to discontinue his relations with that Company under the present schedule. If it be the action of the Society that we shall not examine for less than \$5, I shall do likewise as regards the New York Life.

DR. C. F. GUNDRUM: This is a very serious business for the members of the Society. I am not an examiner for any company at present, and I have no financial interest in the matter, but I do not believe that this Society should

back down to a rich insurance company. The companies have piled up millions upon millions, and we are the men who have helped to pile up their wealth, and we are the men they must depend upon. I think we are in as good a position to hold out for the \$5, as they are to try to get the work for less. I am sure that the insurance companies cannot afford, at least in this city, to go outside of this Society to get first class men, if they want first class risks. As far as I am individually concerned, I do not want to nor would I care to make a careful, thorough examination, as required, for less than \$5.

DR. G. L. SIMMONS: I expressed myself at our last meeting quite strongly in favor of the sentiment as expressed in the report of this committee. The reasons are so well set forth in that, and expressed by several of our members, that I do not think I can add anything to it except that I believe the report should directly mention the names of those companies that have initiated this effort to reduce our incomes from this source. I believe that the New York Life and the Equitable Life should be mentioned, by not only announcing that they initiated this movement, but that we decline particularly to examine for these companies. I think, also, that, as a Society, we should send a protest which will be likely to be copied into the secular as well as the medical journals, setting forth the grounds upon which our actions are based, and that this protest be a respectful one, and addressed to the management of those large corporations. This initial action of our Society, although a small body, comparatively, may be a vital one in its influence upon other societies in this State and throughout the country. I believe members of our profession generally, feel as we do, and I believe we should not submit without setting forth a manly protest. In relation to this subject of fees, in every direction we find they are getting lessened, and we are going to have more difficulty in the course of time; more difficulty with our patrons. We all know that the profession is not being supported as it was. A very apt lesson comes to us in an old country journal, where we are told that a leading grocery firm in Liverpool agrees that all patrons who buy a pound of tea each week, shall receive the gratuitous services of physicians of the Royal College of Physicians and Surgeons of England. I would also wish these resolutions to be very emphatic about naming those companies, and that if they do not recall their action, that we, as individuals and as a Society, shall use our best efforts against their organizations. Something must be done, and something that will be likely to appeal to their pockets, and if the thirty members of our organization can take from their incomes a considerable sum per annum, and if, throughout the country the profession feels as we do, there is not much danger of the business going to the irregulars.

DR. F. D. TYRRELL: I was approached by an officer of the New York Life Insurance Company, and he agreed to pay me \$5 for every examination I conducted for it. I am also examining for the Pennsylvania Mutual Life of Philadelphia, for a fee of \$3, for \$1,000 or under. If these resolutions are adopted, I shall tender my resignation to both of these companies.

DR. H. W. STRADER: I was formerly one of the examiners for the Equitable, and when they reduced the fees, they sent me notice of it. I sent a communication back to them and have not made any more examinations. I look on this matter somewhat differently from those who have expressed an opinion. My idea is that this action is going to throw the work to the irregulars and give them more leverage. I think the companies will do this. I think it would be better to protest against the action of these companies, and not throw up the business, but stop using our influence, and stop carrying insurance with them, and pass resolutions to that effect.

DR. W. H. BALDWIN: It is a difficult question to decide, in my mind, as to what is the best plan to pursue. There is no doubt but that all "old line" companies are going to reduce the fees of their examiners. I have had it intimated to me that a local company of California proposes doing so. The difficulty, in my mind, is to get concerted action throughout the United States on this particular matter. The monopolists are crowding everything down to the lowest ebb, and if regular physicians are not capable of stemming the tide, we shall have to go with it. I certainly do not care to make any examinations for any "old line" company for less than \$5, as heretofore. But the question is, Shall we throw up these fees when the prospects are that we cannot get concerted action?

DR. C. O. CARTWRIGHT: While I am not examining for any company, I am in favor of protesting against anything less than \$5.

DR. D'ARCY POWER: I quite agree with the general statement, and I believe in a fight if you can win it. I feel it is bad policy to throw a great portion of this work into hands where it should not go. If I felt that this thing would be general throughout the Society and throughout this State, I think there would be something in it, but if only done to make a stand of this kind against such corporations, I think it is hopeless, and besides, it will throw the whole work into the hands of those who should not have it.

DR. L. A. HARCOURT: I am not personally interested in this question, but it seems to me that, like almost every other question, there are two sides to it. I question as to whether it is right for this Society to do anything that will injure the individual interests of other members of the Society. It seems to me that the resolutions are expressed in strong language. It is a business question, and it is a business question with us, too; a question of bread and butter for the support of our families, a question of laying up something for old age. I doubt very seriously whether this Society, or any other, has a right to curtail the income that any member has for himself and family. Why not wait until the matter is taken up in the great medical centers of Boston, Chicago, and other places, and until it has been discussed in the medical journals. We ought not to play "dog in the manger," and it seems to me that we should not keep others from making a living who need it.

DR. H. L. NICHOLS: I am in favor of the adoption of the resolutions. I do not believe in making examinations for less than \$5.

DR. WM. ELLERY BRIGGS: I have no personal interest in the matter, but I am in favor of supporting the resolutions. I think the tendency is to cut medical fees too much in every respect. I differ from the views expressed by Dr. Harcourt. He says the older and abler members injure the younger ones who might do that work for less money. I think the effort of the profession should be to keep up fees, as it is of the greatest benefit to young men—those who are beginning. It is also a benefit to any new man coming in, because if the fees are cut down he has a harder time working for \$1.50 than where they are kept up to \$3, and his income is very much lessened. In the matter of life insurance, younger men, who are doing less in general practice, get more of these examinations than men who are busier and do not care for them. The effort of the general profession should be to hold up fees and try and make the companies pay what is, in all justice, nothing more than fair for the work. This cannot injure the younger and struggling men; on the contrary, I think it is for their benefit. Insurance companies are too intelligent to run business in any other way. They know that the regular profession is to be considered, and that without its aid their income would be vastly reduced.

DR. HUNTINGTON: If it is thought best to postpone final action upon the matter, I should make no objection to that. All I want is to hear the matter thoroughly discussed and to get a fair expression of opinion. I hope that these resolutions will be adopted by a large majority. I should, in a certain sense, deplore their adoption by a bare majority, as it would leave us in bad shape in future. The harmony of this Society should go broadcast all over this coast upon this question, and if it is adopted in the right spirit it will do more to advance the Sacramento Society for Medical Improvement than any other measure that has ever been brought before us. It has been said that this business will fall into the hands of the irregulars. The answer to that is brief: It has been made already. The authorized agents who solicit business have always been the staunchest supporters of the regular profession that we have in the United States, because it brings dollars and cents into their pockets to have the best services that can be obtained. It seems to me that to succumb in this matter is beneath the dignity of the profession. If we say that we will take half a loaf instead of none, we are doing just what has been done by all weak people. It is the part of a weak person to succumb instead of meeting the obstacle squarely and thrusting it aside, but the temptation is to get around it. I believe it is possible to win this fight, as I think this feeling is universal from one end of this country to the other, and provision should be made for these resolutions to go into the hands of every State Society in the country, and also to the American Medical Association.

THE PRESIDENT: While I believe in the spirit of the resolutions, I think it is a question we should consider very carefully and thoroughly, because I fear we are going to split upon this rock. Dr. Power has said that if these resolutions are adopted and become binding upon this Society he will not abide by it, and there are other members who will not do it. It is simply a matter of honor whether members abide by it or not. There is no law in this land whereby this Society, by a vote, can oblige Tom Brown, for instance, to charge \$5, unless he sees fit to do it. It would be simply a question of honor whether he would abide by a vote of the Society. It seems to me that we are getting into deep water. I will say that men who resign and will not examine for \$3, have a perfect right to do so, and if every member would stand by that resolution and would refuse to make examinations for less than \$5, after awhile we would get it, because the business end of these companies knows that their support lies in the line of the regular profession. While there is no immediate necessity of adopting these resolutions to-night, it would seem to me well that we spend another evening over this matter.

DR. SIMMONS: I was asked to introduce this discussion, and without any consultation with the other members I expressed my views. I am very much in favor of a postponement and of due deliberation, but I am grieved to see the sentiment that has been expressed here to-night. I can only attribute it to a lack of information of the nature of our organization. The history of medicine and of medical men in this city is familiar to me, and I well remember the time when there was no Society, no harmony, no fee bill, no professional honor, except as the individual made it. That condition of things brought about a distrust of every medical man, and we became the laughing stock of intelligent men in this community. We found our fees at variance with the views of all the community. One man was charging \$1, another \$1.50, and so on. I believe, as I have said before, that the adoption of that fee bill elevated every member of the medical profession in this town who was inclined to be honest and regular. I know it did one thing, and that is, after the fee bill became established we had no trouble having our bills against estates being allowed by the Courts, whereas prior to that time there was a question as to the worth of our services. If any gentleman here charges 50 cents, 75 cents, and \$1, it will soon result in the rejection of that fee bill by the local Judges, and we will all be injured. Now, to come back to this question, I do not disclaim that I have no personal interest in it. I have declined for several years to have anything to do with these companies. I have contended for years that the profession, if it were not to be further degraded, should rise in its might and express itself as to the value of its services. Look at the amount spent in education. Does any one pretend to say that life insurance associations could be maintained if the regular profession declined to take their business for less than \$5. Dr. Baldwin has told us to-night that our main local company contemplated reducing the fee. Suppose that every man should refuse to touch the business, no one will imagine that the Medical Director of that company would throw the business to the homeopaths and irregulars; not at all. If the profession say that they will not handle it for less than \$5, they will get it. Upon what body of men connected with life insurance does this blow fall? The very body of men upon whose aid and weight and knowledge this whole business rests.

Upon motion, final action upon the resolutions was postponed until the next regular meeting.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, December 10, 1895.

The President, WM. FITCH CHENEY, M.D., in the Chair.

Dextro-Cardia.—**DR. ALBERT ABRAMS** presented a case of dextro-cardia [patient exhibited] in a man 45 years of age. The patient had sought advice on account of emaciation and weakness. The mal-position of the heart was caused by an interstitial phthisis. Tubercle bacilli were found in the sputa only after the application of a method which the speaker believed was original with him. This consisted in digesting the sputa with an artificial gastric juice in a water bath or thermostat, and after digestion was completed in pouring off

the supernatant fluid and neutralizing the sediment with a few drops of caustic potash. The subsequent steps were identical with the conventional manner of staining. The results achieved by this method were superior to others in vogue for the examination of the sputum when the tubercle bacilli were, presumably, few in number. For the treatment of this patient he had employed the pneumatic cabinet, purely for its gymnastic effects on the lungs, and for the aerial lavage of a large cavity in the right axillary region. The speaker also exhibited and demonstrated a portable apparatus—the *pneumatic cup* for bedside use in hospital or in private practice, the idea being to secure an action similar to that of the pneumatic cabinet.

DR. D. W. MONTGOMERY: I do not see how Dr. Abrams' method of acting on the sputum by artificial gastric juice is, in any way, superior to its treatment with caustic potash which digests the mucus just as thoroughly as any other preparation. I would like to inquire what he uses to mount the sputum, or whether enough glutenous material is left to render any balsam unnecessary. As to the pneumatic cup, it seems to me to be much the same as the old dry cups, and I rather doubt all of the efficacy claimed by Dr. Abrams for it.

DR. J. H. BARBAT: A method I make use of where there are few bacilli and a quantity of sputum, is to mix the sputum with distilled water, soak thoroughly, and place in a centrifugal separator; the sediment will contain everything. It is more rapid than the digestive method and equally reliable.

DR. LEO NEWMARK inquired whether Dr. Abrams believed he was the originator of this method of staining.

DR. ABRAMS, in replying, said he had never heard of it before, and therefore considered he was the originator.

DR. S. S. HERRICK read a paper entitled "Some Cases of Ethics."

DR. C. G. KENYON: This paper brings up a subject on which much can be said. It involves the prosperity of some and the wearing of old clothes by others. The attainments of some that succeed are not equal to those that fail.

DR. G. F. SHIELS: The sooner the phrase "Code of Ethics" is dropped from medical literature the better. Let every man behave as his own conscience directs.

DR. HENRY GIBBONS, JR.: If physicians only would, then there would be no need of the Code; but as they do not, we certainly need it.

DR. SHIELS: I cannot let it go on record that any set of laws are for the guidance of gentlemen.

DR. C. G. KUHLMAN: Where we need a Code, and a strong one, too, is right here in San Francisco. A case in point recently came to my notice. A certain young physician here had under his care a patient injured on the railroad. The "railroad surgeons" stated that they would hold a consultation with him at 11 A. M. At that time the young man went there and found the others had been there at 9 o'clock, had examined the patient, and treated the case. Such cases are frequent.

DR. D. W. MONTGOMERY reported "A Case of Belladonna Poisoning without Dilatation of the Pupils, caused by a Belladonna Plaster."

DR. K. PISCHL: This case is certainly a valuable addition to our literature. What is to me, from an ophthalmological standpoint, especially interesting, is the fact that, in spite of the general symptoms of atropine poisoning, the pupils were not dilated, though, as a rule, they are very sensitive to this drug. Dr. Edward Jackson, of Philadelphia, found, after the instillation of one-third of a minim of a 1 to 500,000 solution containing $\frac{1}{1500000}$ of a grain of the drug, a slight mydriasis after 24 hours. Instillation of atropine solution, when frequently repeated, sometimes causes general symptoms. I find that a case has been reported in which this occurred in a child 4 years of age, in whose eyes atropine solution had been instilled for three days. From my own observation I have found the newly introduced mydriatic scopolin more apt to create general symptoms.

DR. E. E. KELLY: This is certainly a very interesting case, and one that will puzzle any of us. Belladonna poisoning without dilatation of the pupils is very rare.

DR. M. KROTOSZYNER: I recall a case of atropine poisoning, some 5 years ago, which shows that we cannot be too careful. A young lady, a patient of mine, was suffering from the night sweats of phthisis, and some atropine pills

were prescribed. Next day a message was sent me that the patient was dying. I immediately went to the house and found her suffering from atropine poisoning, though the pupils were not so widely dilated as one would expect to find in such cases. When she was out of danger, I went to the druggist to see how the prescription had been compounded. I had ordered ten pills, each to contain one $\frac{1}{100}$ of a grain. He said that he did not have so small a weight, so he "just took a little bit," and was surprised that any bad results should follow.

Multilocular Ovarian Cyst, and Multiple Uterine Fibroids.—DR. H. KREUTZMANN exhibited a large multilocular ovarian cyst, and a uterus with multiple fibroids, removed by laparotomy, from the same patient. The case presented some interesting features. Patient was 36 years of age, married 20 years, had never been pregnant, menstruation regular, though painful at times. During the past year she thought her abdomen had been growing steadily larger. The attending physician had made a diagnosis of ovarian cyst. On examination, a large cyst was found on the right side of the abdomen, giving an indistinct sense of fluctuation. The uterus was enlarged, but in normal position. There seemed to be some protrusion from the cyst, reaching down into the pelvis. Patient entered the German Hospital, and upon opening the abdomen, a large non-adherent ovarian cyst presented itself, which was easily removed. It was found that, while presenting on the right side of the abdomen, it originated from the left ovary, turning the uterus around its axis. The uterus exhibited a number of fibroids, and it was decided to remove it also, which was done in the usual way. The silk ligatures of the parametrium were pulled down into the vagina, thus bringing the peritoneum of the *cul-de-sac* and of the bladder in contact. A few days after operation, fever set in, and an infiltration developed on the right side of the pelvis. This gradually became smaller and the patient left the hospital. The infiltration, however, returned, somewhat larger than before, and with much tenderness, and accompanied by a slight rise of temperature. She was readmitted to the hospital, and an incision made along Poupert's ligament, and through drainage into the vagina established. Very little pus was found. The drainage tube was soon withdrawn and the swelling gradually disappeared. Patient's condition has since steadily improved; there is now no trace of infiltration of the pelvis, and she is enjoying excellent health.

Amendment to the Constitution.—The amendment to Article II of the Constitution, proposed by DR. C. G. KUHLMAN, was brought up for consideration. The article, as amended, reads as follows: "The objects of this Society shall be: first, to advance and cultivate medical science; second, to promote and protect the interests of the medical profession." The amendment was unanimously adopted.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, September 21, 1895.

The President, W. WATT KERR, M.D., in the chair.

Hysterical Paraplegia.—DR. G. C. MACDONALD presented a case of hysterical paraplegia in a young man 19 years old, with the following history: J. F—, nativity, England; age 19; never had any diseases of childhood except incontinence of urine, which has been constant ever since he can remember, and which had been growing worse up to the present illness or accident, when it ceased. Family history good; father aged 42 years, mother aged 40, suffers, however, with rheumatism. Patient has five brothers and four sisters, all healthy; one sister died of brain fever. The present illness dated from the 28th of May, 1895, when, at 4 A. M., while engaged in trimming lamps at sea on the British ship *Sierra Nevada*, he was struck by a heavy sea and knocked on top of the windlass, landing upon his back. The patient tried to reach the fore-castle, but found that his two legs were paralyzed. On getting out of his bed he noticed his clothes wet, and he would pass water of clear color without his knowledge. About a month after the previous accident the patient fell out of bed, striking on the back of the head near the junction of the occipital and

parietal bones. Ever since then the patient would have cataleptic fits periodically, the unconsciousness varying from 15 minutes to 48 hours. On physical examination tenderness in back on pressure over the vertebral spines from the last dorsal to the upper border of the sacrum was found. On pressing here the patient, rapidly enters into a condition of opisthotonos and catalepsy; the arms being put in any position remain so; the pupils become dilated, the left more than the right; the face and head become flushed; no strabismus. The legs are extended and rigid, but not always, and adducted so that the knees are pressed together. There are present muscular twitchings in both thighs. The epigastric and abdominal reflexes are exaggerated, as is the cremasteric, though there is no erection of the penis. The knee jerk is present, also slight plantar reflex; no ankle clonus. There is no sensation to heat felt below a line two inches above the umbilicus, nor sensation on pricking by pin up to the same point, except on the left side, where the pin sensation is two inches higher than on the right. Anesthesia on the back extends to the tenth dorsal vertebra. The general muscular condition is good. On deep pressure, the pain goes from the end of the sacral to the tenth dorsal, and the deep pressure immediately sends him into a cataleptic fit. Patient does not sleep well; some nocturnal delirium. The pulse is 84, respiration 16, some rise of temperature at night. The patient was put on bromides, then cannabis indica, from $\frac{1}{6}$ to $\frac{1}{2}$ gr. After a week he could feel his limbs, and in two weeks after he got up and walked with only slight trouble in the right leg. At one time the patient accidentally chewed and swallowed 34 cannabis indica pills, but it was discovered in time, and a hypodermic of apomorphine saved him. At the present time he is doing nicely.

Brain Tumor.—DR. MACDONALD also exhibited an interesting specimen of a brain tumor in the tempo-sphenoidal lobe. The following brief history was given: Four years ago patient complained of failing eye sight, which was due to a descending optic neuritis. The history of syphilis was denied, but when put upon iodide of potash the sight returned to one-half normal. He was treated in this manner for about two years, when he finally drifted away. He went to several doctors and to several hospitals. During this time he had no iodide treatment, and became perfectly blind and suffered with fits, when he again came under the speaker's care. He was placed in St. Mary's Hospital, and put upon large doses of potash, with great benefit. The patient was feeling splendidly to the day of his death, which was evidently caused by cerebral hemorrhage. The tumor was quite large and occupied a position in the tempo-sphenoidal lobe; it was not adherent, and was evidently a gumma.

DR. MACDONALD also exhibited a sub-serous fibroid of the uterus, the pedicle of which was treated intra-peritonally. A spindle-celled sarcomatous tumor removed from the pectoralis major was also shown, and a melanotic sarcoma removed from the ulnar border of the palm beneath the little finger.

DR. D. W. MONTGOMERY: We often find the melano-sarcomas in the corresponding portion of the foot, on the back of the heel, where they are supposed to be developed by traumatism in that region. These sarcomas have a tendency to return, and are classed differently. They are quite frequent. In the skin they come from the pigmented layer; they are often formed in the choroid of the eye, in which they show a tremendously rapid growth. I remember a case of Dr. Martinache's, which was seen by Dr. Powers a few days later, where great destruction was shown during a short time. In the eye the prognosis is not so bad, the eye being so delicate the tumor is easily diagnosed, and an early removal is the result; whereas in the skin we would not pay any attention to a tumor that, were it in the eye, would call for an operation.

DR. H. KREUTZMANN: Several years ago a case of melano-sarcoma came under my observation. It was of the foot on the small toe, and was excised. A short time afterward the patient died, and a general sarcomatous condition existed, the liver and other organs being affected.

DR. MONTGOMERY: The pigment seems to be manufactured in the connective tissue itself, the general supposition is that it comes from the hemoglobin or pigment of the blood serum itself. I have here to-night a specimen of a sarcoma of the kidney and suprarenal capsule, which was removed from a child some time ago by Dr. Kreutzmann, who reported the case before the Academy at the time. The sarcomatous kidney was removed, and in the course of a few

months there was a recurrence. This grew to an enormous size, and must have penetrated the vena cava and formed metastases in the lung through the vena cava inferior and right heart. The parietal walls of the peritoneum were covered with small tumors. The tumor is very soft and cellular, and of a very rapid growth. Its glandular structure is similar to the glandular structure of the body. It contains many large endothelial cells, which, from their size, could not cause metastases through the circulatory system direct. The other kidney was found greatly hypertrophied, being nearly as large as a man's, though the child was only $2\frac{1}{2}$ years old. This was evidently one of the reasons that the operation was a success. As this kidney was already doing the full work, there was no extra strain thrown upon it by removing the diseased one.

DR. KREUTZMANN: The first signs of recurrence in the case just mentioned were noted about 10 or 12 weeks after the operation. Previous to this the child had picked up nicely. The bad prognosis was pointed out by me at the second meeting of the Academy after the operation, where it was shown that out of 49 or 52 cases reported and operated upon, none lived over a year, excepting in one case that had been operated on very early when only a slight nodule existed.

Perineorrhaphy.—DR. KREUTZMANN exhibited a patient upon whom perineorrhaphy had been done for a complete laceration of the perineum. Patient is 25 years old, married 5 years, has had three children. With the first she was torn badly, and several attempts at restoration were made, but without success. The perineum was torn completely through the sphincter ani; the patient has not full control over feces and gas. The uterus was small, in good position. The cervix was torn bilaterally. The patient was operated upon under chloroform at the City and County Hospital, on the 6th of last July. Emmet's operation was first performed, then the perineum was repaired in the following way: The sharp border line between the rectum and vagina was incised transversely from right to left. This incision was extended downward over the retracted ends of the sphincter ani muscle, and the vagina and rectum were separated bluntly 2 to $2\frac{1}{2}$ inches high. The transverse incision was united vertically, special care being taken to bring the levator ani and muscles together, and to unite the vivified edges of the anal sphincter with a few buried catgut sutures. The external wound was closed with silkworm gut. There was a slight abscess of one of the external stitches near the anus, from which a small perineo-anal fistula, outside the sphincter, followed. The result is perfect. Patient has full control over feces and gas. The play of the muscles can be beautifully seen when the patient contracts or relaxes the anus.

Vaginal Hysterectomy.—DR. KREUTZMANN also exhibited two uteri removed through the vagina, and gave the following history of the cases: *Case 1*—A lady, 68 years of age, presented herself at the San Francisco Polyclinic, suffering from complete prolapsus of the uterus, with a large cystocele and small rectocele. Different pessaries had been applied without benefit. Freund's operation, as devised for prolapsus in old women, was done at the Polyclinic. This operation, original with Prof. Thiersch, for prolapsus uteri, consists in inserting rows of silver wire into the prolapsed part. The beginning is made near the vaginal portion, the wire is carried under the mucous membrane, in purse-string fashion, and tightened as much as desirable. The next wire is introduced $\frac{1}{2}$ inch distant from the first, and so on, as many as necessary, the last in the introitus vaginæ. Another case was operated on at the County Hospital, by the speaker. In both instances, a relapse occurred after some time. This operation recommends itself through its simplicity, but is by no means reliable. Dr. Gaertig, in *Centralblatt f. Gynäkologie*, 1895, No. 22, reports 7 operations, 5 of which had relapsed at the end of the year. On the 7th of September, under chloroform narcosis, vaginal hysterectomy and extensive plastic work on the vagina, was done at the County Hospital. The incision was made over the cystocele, in the median line, beginning at the meatus urinarius, and extending to the vaginal portion; also a transverse incision around same. The bladder was separated from the vagina, far back on the sides, and from the uterus. The vesico uterine and recto-uterine pouches were opened, the parametrium and ligaments tied with silk, and the uterus removed. An extensive piece of vaginal tissue, on both sides of the median incision, was cut away, and the wound carefully closed with silkworm gut. A colpo-perine-

orrhaphy (Frietsch's) finished the operation. Union was perfect. Patient is up and around. Hysterectomy is certainly not to be done in every case of prolapsus. Certain diseases, as carcinoma, will necessitate its extirpation. In cases like the one reported, the uterus is of no value whatever to the bearer; through its weight there is considerable dragging upon the parts; the plastic operation is scarcely complicated through its removal. *Case 2*—M. C.—, aged 32, married 10 years, no children; has been suffering for years from pelvic trouble, which has been kindled over lately. When patient entered the German Hospital, on the 7th of August, 1895, she had a temperature of 103° F., pulse, 120, intense pain in pelvis, no sleep, no appetite, and much emaciated. The uterus was pushed toward the symphysis; pubis perfectly immovable, all around it an infiltration was felt; on the left of the uterus this infiltration was doughy and in a few days an abscess formed there, reaching over Poupert's ligament. On the 25th day of August an incision was made along Poupert's ligament, some fetid pus was evacuated, a counter opening made into the vagina, and the cavity flushed and drained from abdomen to vagina. The temperature went down a little, but the patient did not have much relief, notwithstanding good drainage was kept up and the wound flushed twice daily with a lysol solution. Soon the temperature went up again to 103° F. In the evening the infiltration began to get doughy on the right side also. On September 7th, vaginal hysterectomy was done, an incision around the vaginal portion was made, the bladder pushed back, the parametria secured with two clamps, the cervix split and cut away. By carefully working with the fingers the fundus was reached. The tissue around the uterus presented a honeycombed condition. A few minor pus cavities were opened, two clamps were applied on each side, and the uterus cut away. The intestines never came into view or touch. The appendages were left behind; the cavity made by the removal of the uterus was packed with iodoform gauze. The clamps were removed 48 hours after the operation, the gauze on the fourth day. Recovery was rapid; patient felt excellent immediately after removal of the clamps, was sitting up in bed the tenth day, and left her bed the fourteenth day. When patient left the hospital, she began to gain flesh. Nothing could be felt in the pelvis, no infiltration, no painful spot; the uterine appendages could not be outlined.

The speaker said: We notice, at the present time, a general revival of the vaginal route for pelvic operations, as against abdominal section. This comes from two sources: from Péan, in Paris, who first did hysterectomy for suppurative disease of the uterine appendages and pelvis. Violently antagonized for a long time in France, he found imitators in Segond, Doyen, and Richelot, Jacobs, in Brussels, and L. Landau, in Berlin. Péan operates almost exclusively *per vaginam*, not only in suppurative disease, but in cases of tumors also, by morcellment. On the other hand, Duhrssen, and many others, among whom Aug. Martin, of Berlin, has lately become an ardent advocate, do "colpotomy" or "vaginal celiotomy," in preference to abdominal section. Duhrssen, Mackenrodt, and others, while improving the vagino-fixation for retroflexed uteri, arrived, step by step, to this procedure. Their method consists in entering the abdominal cavity through the vesico-uterine pouch. Tumors of the adnexæ and tubal pregnancies, have thus been successfully removed. No doubt exists that vaginal hysterectomy (with or without removal of the appendages) in suppurative disease of the pelvic viscera, has come to stay; marvelous results have been obtained in the most severe cases. The immediate results are excellent, the mortality being from 2 to 4 per cent. Recovery is rapid, remarkably so as compared with the tedious, unsatisfactory convalescence of some cases of abdominal section for pelvic suppuration. But it is not the proper thing to do this operation instead of celiotomy in all and every case. Just prior to the rush for vaginal operation, we had arrived at a very conservative treatment of inflammatory diseases of the uterine appendages, such as resection of the tubes and ovaries—salpingotomy. If vaginal hysterectomy is done wantonly instead of celiotomy, there is great danger that many a woman will be rendered hopelessly sterile, where, with a more conservative operation, the functions of the uterus and its appendages would have been saved. An excellent summing up of the indications for vaginal hysterectomy in inflammatory disease is given by Dr. Garceau, in an article, "Vaginal Hysterectomy, as Done in France."¹ On the other hand, the enthusiasm for Duhrssen's "Vaginal

¹ American Journal of Obstetrics, March, 1895.

Celiotomy," should be considerably lessened when we read that Mackenrodt ("Ueber einige neuere operations methoden," *Monatschrift f. Geburtshulfe und Gynäkologie, ergänzungekeft*) had to do hysterectomy four times under 30 colpotomies, in order to save the life of his patients, which was endangered through hemorrhage resulting from lacerations of the ligaments; these operations were undertaken with the hope to cure sterility.

DR. G. GROSS: I remember one severe case in the New York Post-Graduate school, where Dr. Jacobs, of Brussels, was invited to operate. The patient had some inflammatory trouble after confinement, and had been sick several weeks, and, at the time of the operation, the temperature was 104° F. There existed a desperate condition of the womb, and it was not possible to save it. The operation was extremely difficult; there was much hemorrhage, and saline infusions were resorted to. Dr. Jacobs' mortality was 4 per cent.

CORRESPONDENCE.

The Reduction in Fees of Medical Examiners for Life Insurance.

Sir: I fully concur with you in your editorial comment on the proposed reduction of fees for examination of subjects for life insurance. If such reduction be carried into effect, it will certainly drive from the companies some of their most competent examiners, and this must jeopardize the financial securities of the companies. If a change be contemplated, a wise and prudent one would be an increase of present fees, which are too low.

I am, etc.,

L. C. LANE,

652 Mission street, San Francisco.

President Cooper Medical College.

Sir: I have read with pleasure your very able article in the January number of THE MEDICAL TIMES, on "The Reduction in Fees of Medical Examiners for Life Insurance," and congratulate you on the fair manner in which you have presented the case and the conclusions you have reached. The point at issue is, Shall the amount of policy determine the medical examiner's fee, all other requirements, as to thoroughness, honesty, skill, and responsibility, being precisely the same? Or, in other words, can a medical examiner have a sliding scale for his conscience, so as to give three dollars' worth in one case, and five dollars' worth in another, because one happens to be a small policy, while the other is larger? If these companies commencing the cut in Examiner's fees divide their risks into classes, according to the amount of policy applied for, and fix the medical examiner's fee accordingly, they should, to be fair, have two or more kinds of examination blanks, those for the smaller amounts requiring less skill and time to make up, reserving the longer and more complicated ones for the larger policies. Time can be measured, if skill and responsibility cannot. These same companies pay their Presidents as much or more salary than the President of the United States receives, and other officers in proportion, and this reduction of the medical examiner's fee looks to me to be a "spigot" economy. Why not cut the agents' commission also? These companies, knowing the competition in all lines of business, expect competition to prevent the concerted opposition of the medical profession, and count on their examiners meekly accepting whatever is offered. For my part, I cannot see how any self-respecting, competent examiner can allow himself to be forced to accept a less fee from a wealthy corporation than he would charge for the same service in his private practice, and if the alternative is, take what is offered or resign—I say, resign. The present cut is not the end, for if \$3.00 is accepted, why not \$2.00 or \$1.00, finally? There are plenty of cheap doctors—some may be forced, by necessity, to accept such a fee. But if the medical profession of the United States (at least the best part of it), will stand together and refuse the proposed reduction, it will be dropped, or at least not adopted by the other "old line" companies. We owe it to ourselves and our profession to stand solidly together and resist what seems to be an unjust and unfair demand.

I am, etc.,

WM. LEMOYNE WILLS,

President Medical Society, State of California.

127 West First street, Los Angeles.

Sir: I can readily endorse what you have written concerning the change in fees paid to examiners by some insurance companies. It is absurd to ask that the same work should be done at two different prices; and if this is done it will soon be followed by a reduction in all the fees. Hitherto it has been the policy to insist upon the examiners being disinterested, but the proposed change is in direct violation of this principle. If there are to be differences made in the rigidity of the examination, according to the amount of insurance applied for, there would be some sense in making a difference in the fee, but that the same amount of medical service should be worth \$3 at one time and \$5 at another is simply absurd, and in a very short time the insurance companies will tell their examiners that such is the case. If the examiner is to be made a participator in the advantages that come to the companies from large policies, why should his proportionate fee stop at \$5,000? Why should he not receive \$10 when the policy is for \$10,000? or \$20 when the policy is for \$20,000? I have already refused to examine at the reduced rate, and trust that others will do the same.

I am, etc.,

WM. WATT KERR,

Permanent Secretary Medical Society, State of California.

528 Sutter street, San Francisco.

Sir: The reduction of Medical Examiner's fees, by two of the leading insurance companies, can hardly have been determined upon after giving the subject careful and intelligent deliberation. Although the same work is involved in the medical examination of a person applying for a \$1,000 life insurance policy as when a \$10,000 policy is applied for, a difference in the pay for such examination cannot help but make the examiner think that the company is not so particular about the \$1,000 policy, which, in the end, must lead to an increase in the number of death losses. The way life insurance business is worked up by many traveling agents, the scientific basis to life insurance is being so limited, that to introduce still more superficialities is to make life insurance a mere lottery. It is a well known fact that where agents are given a choice between several physicians, or are at liberty to select the examiner themselves, they will almost invariably go to the physician who is known not to be too strict or conscientious in his examinations. To a medical man, therefore, who realizes that a thorough medical examination is essential in order to come to any conclusion as to the present health of an individual, it would seem that this determination on the part of the two insurance companies must of necessity act like a boomerang.

I am, etc.,

A. W. HOISHOLT,

Stockton, Cal.

President California Northern District Medical Society.

Sir: Your able review, in the January number of THE TIMES, of the effort by life insurance companies to reduce the fees for medical examinations, should have the voluntary and unanimous endorsement of every member of the regular medical profession. To my mind this is an issue which involves very much more to the self-respecting and profession-respecting practitioner than the loss of a fractional part of the fee for each examination made—though this item, alone, deserves most determined and united opposition. With life insurance companies this is purely and simply a question of economics, which they figure scientifically, and which they operate according to that method which yields at once the greatest safety at least expense and with highest profits. The medical examiner is a necessary part of the machinery; his efficiency they would maintain by exaction, but his expense, to them, they propose to reduce by dictation. It is their policy and strength to make such terms, and they assume that a sufficient number of impolitic and compromising physicians will accept these terms to serve their purpose. According to our own estimates of ourselves and our services, we will accept or reject such conditions. Whether a reduction of fees for medical examinations will ultimately work good or ill to the insurance companies does not directly concern us, and can only be demonstrated by experience. But it is a question worthy of a financier's consideration whether a service arbitrarily depreciated 40 per cent. can be rationally expected to maintain an efficiency of 100 per cent. We susceptible country physicians must not be deluded by the prospect of increased fees for examinations for large policies; such opportunities in the past were too rare to affect the account; and we all know that large policies are now almost never taken outside the large cities. Within ten years I find I received two "extra fees."

Besides, unless the companies graduate the work and responsibility of the examiner according to the size of policy, I see no force in the small policy; *ergo*, small fee argument. While medical men consider the expediency or inexpediency of accepting this particular reduction as stated, much more serious thought should be given to the ethical principle which is herein put to the test. Granting that every medical examiner is conscientious in his work, and that he appreciates his responsibility, both to the applicant and the company in every case, can any competent physician accept this reduction without compromising his professional merit and lowering the dignity of his profession? Our services are estimated at just what we ourselves show to be our low-water mark. Those who employ us place our maximum value at our minimum charge. That insurance companies will take our best services at the lowest possible figure is but natural; it is legitimate business, and is exactly what we must anticipate. Hence, the question for us is not what will these companies do, and why? (their course is plainly stated) but what shall we physicians do or not do, and why? Again, is the medical profession wholly innocent in this matter? Observation raises in me the embarrassing suspicion that "negotiable" conduct by "regular" physicians has exposed a weakness within our ranks for professional bartering, of which the "old line" companies are taking advantage with characteristic shrewdness. Seeing that many "old line" physicians throughout the nation hire themselves out to serve lodges, orders, etc., for a nominal allowance per capita, per annum, and noting other schemes to catch a dollar, would not their clever processes readily carry the analogy to the conclusion that these men would submit to whatever reduction of fees they chose to offer rather than lose the business? I confess these are distasteful reflections, and I would gladly see the profession show them to be unfounded; yet my confidence in the members of the medical profession persuades me that where indifferent remuneration is accepted, it is done as a temporary step to meet immediate necessities, and not with the consciousness that the strength of the profession is by every such concession seriously impaired. As we sincerely believe and feel the justness of our opposition to this reduction, let us have the courage of our convictions and stand unitedly for what we fully earn; for what many of the fair-minded representatives of these companies concede is right. To accept this reduction means not only the yielding of our professional independence and individuality in this particular instance, but may assist in inaugurating a system of restrictions the results of which our best actuaries cannot estimate.

I am, etc.,

H. D. LAWHEAD,

Woodland, Cal.

Ex-President Cal. Northern District Medical Society.

Sir: I am clearly of the opinion there is nothing just in the proposed reduction of the fees of the medical examiners contemplated, and actually put into effect, by some of the prominent "old line" companies. The care, responsibility, skill, and labor are the same whether the policy be for \$500 or \$5,000. The confidential information the same which the company always expects from its medical examiners, which is often worth more to the company than the fee they pay for the examination. When we take into consideration that most of the policies applied for from the interior are small, the examiners who live in the smaller interior towns will feel this reduction the most. To the argument that I have heard advanced, that the examiner is always certain of his fee, whether the applicant be accepted or rejected, when in his ordinary business he makes many calls and rides many miles for which he receives no compensation, I have this to say: It is not in keeping with the hitherto liberal policy of the companies I have the honor to represent, because an examiner does charity work, he should, for a rich corporation, be asked to make a reduction in his fees. I am not disposed to censure a corporation for attempting to economize, but I think this is the wrong place for economy to begin. The companies always expect the most skilled work they can get, and select their examiners with great care. I have heretofore regarded it as a compliment that one might well feel proud of to represent one of the prominent "old line" companies as its examiner, and have always taken great pride in this work, and used for them all the skill I possessed, for they have been liberal and prompt in their dealings with me, but I think it not fair treatment to make this reduction. I think there should be some concert of action on the part of the profession in this matter, and am glad to see you have taken the matter in hand, and I am

with you heart and soul. There is just one other point. You take an examiner who has lived in a community for 15 to 20 years, and is well acquainted with most of those who apply for insurance, and has had more or less to do with them professionally for years, this knowledge, which the company expects, and I might say exacts, is something you can scarcely over estimate.

I am, etc.,

O. STANSBURY.

Chico, Cal.

Treasurer California Northern District Medical Society.

Sir: In my judgment the insurance companies that have reduced the fees of their medical examiners, have committed an error that will result, sooner or later, to their injury. I have always contended—and still firmly believe—that the office of examiner is the most important, the most responsible in life insurance companies. Upon his skill, care, and conscientious performance of duty, depends, very largely, their success, as well as the interest and protection of the policy holders. I cannot avoid the conviction that those companies that are paying a small or graded fee would be more successful if, at the beginning of their careers, they had granted a more liberal and uniform compensation to their medical examiners. The so-called assessment companies, and fraternal insurance organizations, are to-day burdened with a large and constantly increasing assessment, because their charters do not permit a more generous and equitable rate for examinations. The "old line" companies are ignoring the existence of these organizations, and yet two of the most influential and wealthy of these have adopted a feature of these societies, that has been the means, in a great measure, of admitting undesirable risks, and rapidly augmenting their mortality rate. Physicians of skill and experience cannot afford to make a thorough and painstaking report upon the physical and mental condition of an applicant for insurance, in any company or organization, for a less sum than \$5, I care not if the amount be for \$1,000 or \$10,000, and be absolutely just to themselves and to the company. Whilst I am pleased with the conviction that a very great majority of examiners were honest, nevertheless there are many of these, when the compensation is small, that are apt to grow weary and careless in making examinations for companies that require the best service for the least expenditure.

G. W. DAVIS.

633 Sutter street, San Francisco.

Sir Referring to your article in the January issue, in relation to the reduction of the fees of medical examiners by certain life insurance companies, I would say, that to get good goods they should expect to pay good prices. The reduction of the fees would seem to indicate an indifference as to the efficiency of their examiners, and a bid for dishonesty.

I am, etc.,

E. B. ROBERTSON,

Vice-President California Northern District Medical Society.

Jackson, Cal.

Sir: The usual fee of \$5, which is paid for a medical examination for life insurance, is only a moderate compensation for the work done. Any attempt to reduce this fee should be strongly resisted by the profession, as an encroachment on its right of demanding fair remuneration for fair services. The medical examination is the most important element in life insurance business, and all companies acknowledge this by requiring the utmost care from all examiners, and by employing only reputable physicians, known to be specially fitted for such work. Without competent medical advice, no insurance company would venture to continue in business. For an insurance company thus to acknowledge the vital importance of the medical examination, and yet to deny that it is worth a moderate compensation, is an absurdity. There is no good reason for reducing the fees, except on the basis of its value to the company, and the value of such examination needs no demonstration. If not based on its value, then the reason must be the belief that the profession would be helpless in the face of a reduction, and the company would stand convicted of taking an unfair advantage. If this action became general among the companies, they would certainly lose the good will of the profession, a loss that they cannot afford, all things considered. I do not see how any insurance company can afford to reduce the medical fees below a fair sum. It is to their interest to encourage thoroughness and care in medical examinations, and an unfair reduction of the fees would be defeating their own ends. It would be a short

sighted policy, and the poorest kind of economy, and an act which, I am sure, will meet with the united resistance of the profession, as a matter of principle.

533 Sutter street, San Francisco.

GEO. B. SOMERS.

Sir: Speaking for myself, I will say, that I will never submit to a reduction of fee for life examinations. A thorough examination (and I will make no other) takes considerable time, and the exercise of all the faculties, in arriving at a just conclusion. The company that refuses a fair compensation for my services, cannot have them. Let them get their work done elsewhere. If the saving to the company by the reduction of medical examiners' fees resulted in that much saved to the insured, I might submit; but it does not. It only goes into the hungry maw of the solicitor. Solicitors of the New York Life get as high as 70 per cent. of the first premium. And now the company is forming an organization known as the "Nyllic," whereby solicitors will become pensioners for life upon the company. Perhaps this reduction in the fees of its examiners, is to supply a part of the funds for this purpose. Let every self-respecting physician, and every medical society, oppose this step on the part of the companies taking it, and refuse their business. Not only that, but let them quietly oppose such companies, and divert all business possible from them. Force the companies to employ "cheap John" examiners, and the work done for them will soon teach them a lesson. It will result similarly to the old darkey preacher's case, when he answered the inquiry about how he could afford to preach for so small a salary, "Well, yo see, sah, hits mighty po' pay, but hits mighty po' preachin'." I am, etc.,

R. F. ROONEY.

Auburn Cal.

Sir: I have read with much interest the editorial in the current number of THE TIMES, in which is discussed the matter of fees of medical examiners for life insurance companies. It is most fortunate that the medical profession have found so able a champion. I hope the article in question will be brought forcibly to the attention of the executive board of every life insurance company, and that it will be placed within the knowledge of all medical organizations, and of all representative medical men throughout this country. Heartily sympathizing with measures you have so ably set forth, it is unnecessary that I should attempt any review of the argument. I have profound faith that the movement inaugurated by you, and sustained by the recent action of the Sacramento Society for Medical Improvement, will meet with a hearty response from all medical men and organizations throughout the land. Assuring you of my personal coöperation, I am, etc.,

426½ J street, Sacramento.

THOS. W. HUNTINGTON.

Sir: The dependence of life insurance upon the skill and integrity of medical examiners has been generally recognized, and until recently the latter have felt that their services were fairly appreciated. Heretofore, the great companies have evidenced, both by word and action, that they want the best qualifications of skill and integrity in their medical examiners, and the best work in their power. Lately, however, two companies have signified that inferior qualifications are good enough for their smaller risks, by reducing the medical fees. I would not impeach their intelligence by intimating that they expect as good service for \$3 as for \$5 from a servant in any capacity; but, admitting that the examiners be selected with as much care as ever before, and have as good professional ability, it is too much to expect that a medical training, alone of all educational methods, will eliminate customary traits of human nature. Among the most common and persistent are sensibility to depreciation of worth, and determination to get even with the aggressor. Now, this reduction of medical fees accompanies increased commissions to agents, and rebates by them to candidates, for the purpose of increasing business. From the medical examiner's standpoint, it looks like speculating at his expense. Heretofore the theory has been, that he is fairly paid to guard the safety of the company, but when his pay is reduced for this service, his sense of duty naturally abates in the same degree. Another point: The habit of agents in allowing rebates on first payments, out of their own commissions, is well known. What is to prevent their offering a bonus to the medical examiner for every favorable report? In view of the well-known fact, that many medical practitioners take commissions from apothecaries, and even undertakers, on the patronage of their patients, would

it be strange for a medical examiner, under a sense of depreciation by his company, to listen favorably to such an overture. A man without a grievance may be trusted, unless a scamp by nature, but the average man, who believes he has been shabbily treated, will be tempted by an easy chance to get even. Louis XI, of France, was a wise man after his sort, in profuse liberality to his barber, who had frequent and easy opportunities to cut his master's throat. He appreciated a sense of security in the man's fidelity, and, it seems to me, that life insurance companies can not afford to count among their risks the fidelity of their medical examiners. I am, etc.,

S. S. HERRICK.

240 San Jose avenue, San Francisco.

Sir: I fully coincide with you in your stand taken in your issue of January against the reductions by "old line" life insurance companies in the fees paid their medical examiners. I am at the present time the medical examiner for a number of life insurance companies, and I am pleased to state that none of my companies have reduced their fees below \$5. Should any of these companies desire to reduce their fees they will receive my resignation, and be obliged to hunt some cheap doctor to do the work. If life insurance companies desire to have responsible men in the profession make honest and thorough medical examinations, and work in the interest of the company, they must pay for the services of such men. Do life insurance companies employ cheap lawyers to present their cases at bar? You will find they select the best attorneys, and pay them well for their services. Consider the risk a life insurance company takes in placing the examination of applicants in the hands of an unskilled or dishonest physician; and such they will be obliged to do if they endeavor to dictate to those who uphold the dignity of our profession. We must stand united as a profession and as societies, and say to these people, "We will not put our profession down on the level of a mere trade." I am, etc.,

ELMER E. STONE,

Marysville, Cal. Secretary California Northern District Medical Society.

Sir: I read your article on "The Reduction of Fees of Medical Examiners for Life Insurance" with much interest, for, though I am not an examiner for either the New York Life or the Equitable, it is plain that, if they succeed, other companies will not be slow to follow. Whether they succeed or fail, depends entirely upon the profession. In this community, we have entered into an agreement not to make examinations for "old line" companies for less than \$5; and they must pay that sum, import their examiners, or quit the field. It seems to me that if such a course were pursued by the profession at large, it would cause those companies to reconsider their action. I am, etc.,

Red Bluff, Cal.

JOHN FIFE.

OBITUARY.

EUTHANASIA S. MEADE, M.D.

Dr. Euthanasia S. Meade was born in 1836, in Genessee, N. J., of the Sherman family, a niece of General W. T. Sherman. She was a twin. At 17 years she married a man, the choice of her mother, and came soon after to California. The death of her only child in its birth turned her attention to obstetrics, and later on to medicine. She spent several years in the East in hospitals during the war, and in the Woman's Medical College of Pennsylvania, where she graduated in 1869. Returning to California, she opened an office on Mission street, San Francisco, then a fashionable part of the city, and was the first regular woman physician to establish herself in California, although at that time she met with little recognition from the medical profession. After some months she was so afflicted with asthma that she moved to San José, where she practised for 25 years, with no return of the malady. Dr. Meade was possessed of rare grace and beauty, combined with good intellectual ability; she was always a student, well read in other lines than medicine; a brilliant conversationalist, quoting extensively prose and poetry which she had memorized. She was a most charming hostess, one whose versatility kept her guests on the alert. She had a most profound contempt for shams, and was merciless in her expos-

ure of them. In 1876, with four other women physicians, the total number then in California, she was admitted to the State Medical Society. A few months later she went to Europe for 18 months' of study and travel. She resumed her practice in San José on her return. Time had removed much of the prejudice against women in medicine. Her honorable work made her well known, and she was loved and honored as among the best of the profession. Her own experience of life in early days in California; the almost insurmountable obstacles to her medical studies; the bitter trials of a woman struggling alone; and more than all else the greatest sorrow of her life, the loss of her child, stamped her whole character. Her life work was to help women to broaden their lives, to encourage by word and deed every woman who came to her. She was often deceived in her protégés, her kindness misplaced, and her confidence unappreciated. Too often she was generous without judgment. Her death was hastened by such an unselfish act. She went last February to Indian Territory, suffered exposure and hardship to relieve and comfort one in whom she believed and who stood alone. Hundreds of bread-winners and students rise up to call her blessed for her words of cheer and deeds of helpfulness. She never wearied in doing as she would be done by. Her illness lasted only a day, and was due to a cerebral embolus from an endocarditis. Her remains, by her request, were cremated at Cypress Lawn Cemetery.

C. B. B.

At a special meeting of the Medical Society of Santa Clara County, held November 2, 1895, the following resolutions were adopted:

WHEREAS, Almighty God in His Providence has seen fit to take from the midst of our profession Dr. E. S. Meade, who during her professional life commanded the respect and esteem of the members of this Society and of the laity, and who elevated the medical profession, as well as the cause of woman, by her sterling character and unimpeachable conduct, hence in her death every member of this Society has sustained a personal loss; therefore, be it

Resolved, That the Medical Society of Santa Clara County unanimously offers its condolence and deepest sympathy to her relatives and friends, and orders that this resolution be spread upon the minutes of the Society.

REVIEWS AND NOTICES.

INDURATIVE MEDIASTINO-PERICARDITIS. By Thomas Harris, M. D. (London), F. R. S. P., Physician to the Manchester Royal Infirmary; Consulting Physician to the Manchester Hospital for Consumption and Diseases of the Throat and Chest. Reprinted from the *Medical Chronicle*, 1894-5. London: Smith, Elder & Co., 1895; pp. 68.

In this monograph the author has exhausted the literature of this rare affection. He reports three cases in detail of mediastino-pericarditis occurring in his own practice. It was Kussmaul who, in 1873, first created an interest in this disease by attaching much importance to the pulsus paradoxus in the diagnosis of mediastino-pericarditis. Increased experience, however, does not confirm the observations of Kussmaul.

OBSTETRIC SURGERY. By Robert H. Grandin, M.D., Obstetric Surgeon to the New York Maternity Hospital, Gynecologist to the French Hospital, etc.; and George W. Jarman, M.D., Obstetric Surgeon to the New York Maternity Hospital, Gynecologist to the Cancer Hospital, etc.; with eighty-five illustrations in the text, and fifteen full-page photographic plates. Philadelphia: The F. A. Davis Co., publishers, pp. 220. Price, cloth, \$2.50.

We consider this to be one of the best works on the subject. The teaching is clear, distinct and forcible, so that the reader is not at any time in doubt as to the course which the writers recommend in the performance of any obstetric operation. The illustrations are good, and materially enhance the value of the book. We can recommend it to our readers as a useful addition to their medical library.

A PRACTICAL TREATISE ON THE DISEASES OF THE HAIR AND SCALP. By George Thomas Jackson, M.D., Professor of Dermatology, Woman's Medical College, N. Y. Infirmary; Chief of Clinic and Instructor in Dermatology, College of Physicians and Surgeons, etc. New revised and enlarged edition. New York: E. B. Treat, pp. 414. Price \$2.75.

In this edition, the whole of the book has been revised and brought into conformity with the progress made in the study of this branch of medicine. The necessity for a special work of reference on this subject must have forced itself upon every practitioner, as there are few things about which the public are more sensitive than disease of the scalp and hair. We can assure our readers that the present edition contains the most complete and comprehensive information on the subject.

THE NURSE'S DICTIONARY OF MEDICAL TERMS AND NURSING TREATMENT. Compiled for the use of nurses, and containing a description of the principal medical and nursing terms and professional instruments, drugs, diseases, accident terms, physiological names, operations, etc., encountered in the ward or sick room. By Honnor Morten. Second edition corrected and enlarged. Philadelphia: W. B. Saunders, pp. 140. Price, \$1.00.

This is a handy little volume comprising all the terms usually encountered by the nurse, as well as many that occur occasionally in hospital practice. It is really a miniature dictionary of medicine, as the definitions, in many cases, occupy from half to one column, thus: Erysipelas is defined, a description of the disease, precautions to be observed, and many other factors being included. The word hypodermic, carries with it a description of the method of giving an injection, and the precautions to be observed. "Pack" includes a description of the different packs in use, as cold pack, ice pack, hot pack, and packing the vagina. Ovariectomy includes a description of the post-operative treatment of patients, occupying almost a column. This plan has been followed in almost every instance, with the more important terms, and the information which the nurse would naturally seek, is to be found under what might be termed the leading head. This little volume, which is neatly bound and clearly printed, seems to be just what we have often heard inquiries for from nurses. It seems to be quite sufficient for the purpose intended, and if its popularity warrants, it can no doubt be improved in future editions.

PRACTICAL LECTURES ON DERMATOLOGY. Comprising a course of fifteen lectures, delivered at the University of Vermont Medical Department, during the session of 1892-1893, by Condict W. Cutler, M.S., M.D., Professor of Dermatology, University of Vermont; Physician-in-Chief and Dermatologist to the New York Dispensary. New York: G. P. Putnam's Sons, pp. 234. Price \$2.00.

This book contains a course of fifteen lectures, delivered at the University of Vermont, during the session of 1892-1893, and published at the request of the students who listened to them. We are not surprised that Dr. Cutler should have received such a request, as the humorous, terse, and yet thorough way in which he treats his subject must have made his lectures both entertaining and instructive. The book is very well arranged, commencing with the anatomy, classification and general therapeutics of the skin; after which the clinical manifestations and treatment of each disease is discussed separately, and the volume closes with a chapter on "Don'ts," which certainly is not the least important part of the information furnished in his lectures. The influence of the author's early religious training is very evident throughout the whole book; it is true that he occasionally shows an inclination to backslide, as when, in the opening chapter, he discards the religio-scientific classification for one based upon a scientific foundation only, but in the chapter on alopecia he nobly retrieves himself, and "evens up" by rehearsing the awful consequences that await the scorner. The book deserves a big sale, and we hope that its merits will be substantially appreciated by the profession.

SEXUAL NEURASTHENIA (NERVOUS EXHAUSTION), ITS HYGIENE, CAUSES, SYMPTOMS AND TREATMENT, with a chapter on Diet for the Nervous. By George M. Beard, M. A., M. D., formerly Lecturer on Nervous Diseases in the University of the city of New York; edited with notes and additions,

by A. D. Rockwell, M. A., M. D., formerly Professor of Electro-Therapeutics in the New York Post-Graduate Medical School and Hospital. Fourth edition, with formulæ. New York: E. B. Treat, pp. 294. Price, \$2.75.

The book is essentially a disquisition on diseases of the male sexual organs and should be so denominated. The authors commit an error which is common in theoretical medicine, that of regarding a symptom as a disease. Thus in describing certain affections of the sexual organs with a recognized anatomico-pathological substratum, they ignore the latter and specify the affection as neurasthenia; a procedure wholly at variance with the dictates of modern medical nosology. The trend of modern opinion is to regard neurasthenia as a subdivision of hysteria, differing from the latter by the intensity of the symptoms and modified by sex. Thus exhausted nervous vitality in the female is recognized by the term hysteria, whereas in the male it is known as neurasthenia. The fact is furthermore recognized that neurasthenia is a neurosis and must never be diagnosed, provided structural disease of an organ can be demonstrated sufficient to account for the protean nervous manifestations. Many of the statements appearing in this work are evasive and unscientific, and the coinage of new terms conduces to further confusion. A high degree of hyperemia of the brain is referred to as a physiological condition. Traumatic neurosis, the now recognized term for "railway spine," is specified as traumatic neurasthenia. The treatment of individual affections of the male sexual organs is not modernized. No mention is made of the "rest cure treatment" in neurasthenia, a therapeutic procedure which may be regarded as one of the triumphs of modern medicine. In the chapter devoted to "The Diet of the Nervous" the author presents certain dietetic rules which are more characteristic of the theoretician than the experimental physiologist. The book should have been rewritten by the accomplished editor, for only confusion results when obsolete opinions are enveloped in the garb of accepted truths.

A MANUAL OF MODERN THEORY AND TECHNIQUE OF SURGICAL ASEPSIS.

By Carl Beck, M.D., Visiting Surgeon to St. Mark's Hospital and to the German Poliklinik of New York city, etc., with 65 illustrations in the text, and 12 full-page plates. Philadelphia: W. B. Saunders. pp. 306. Price \$1.25.

This excellent little book is essentially practical in its treatment of the subject of surgical asepsis. As the author truly says: "Bacteriology has revolutionized the practice of surgery," and the grouping of the principles that underlie modern wound treatment with the methods necessary to insure success, in a small, compact volume, well up to date, is a distinct advantage. The author first takes up the subject of germ life and its influence on the healing of wounds. The importance of asepsis, the means of disinfection, and the necessary apparatus are next reviewed. The preparation of surgical instruments and material are handled in a most intelligible manner, and a constant effort made to demonstrate, not only the absolute importance of thorough disinfection, but the comparative simplicity of the means by which this can be attained. The management of aseptic and of septic wounds, with the different methods of treatment, are clearly discussed. The operative *technique* demanded by advanced surgery, is clearly laid down, and careful adherence to detail is rigidly insisted upon. By far the most valuable chapter in the book is that on "Asepsis in Private Practice." This may not interest the specialist, but if this chapter, or the principles that it enunciates, could be permanently impressed upon the profession, it would be the means of saving many lives. Its seventeen pages contain a mine of common sense and of truthful criticism. To our mind, the distinct value of the book is, that it robs modern surgical *technique* of its mysteries and its difficulties, by a clear enunciation of the underlying principles and by practical demonstrations of the ease with which the end sought for can be realized. Some of the author's views will be criticized, such as his absolute abandonment of catgut as a material for suture or ligature, on the ground that it is impossible to insure sterilization. The time assigned for the sterilization of instruments and dressings will be regarded by many as too short for absolute certainty, yet in this, more than in any other subject, it is results that tell the tale. In heartily commending this book, we would suggest to the publisher that he could greatly increase its utility, and perhaps its sale, if it were issued in a more compact form and with a flexible cover.

AN INTERNATIONAL SYSTEM OF ELECTRO-THERAPEUTICS; FOR STUDENTS, GENERAL PRACTITIONERS, AND SPECIALISTS. By Horatio R. Bigelow, M.D., and thirty-eight Associate Editors. Thoroughly illustrated. In one large royal octavo volume, 1160 pages. Philadelphia: The F. A. Davis Co. Price, extra cloth, \$6.00 net; sheep, \$7.00 net; half-Russia, \$7.50 net.

The appearance of this work may be regarded as very opportune. The growing importance of electricity as a therapeutic agent is being recognized, and a demand for more exact knowledge in its application is felt. The practitioner, as a rule, is very deficient in his knowledge of electro-physics and much of his work, therefore, is in the dark and by rule of thumb. It is not asserted that certainty in electro-therapeutics has been attained, for much of it is still empirical, but with a better knowledge of electro-therapeutics, and of the management of electrical appliances, there must necessarily follow more precision. We believe that, for the first time, exactly this knowledge has been presented to the profession in an extended form and in one volume. The preface of the book, contrary to the usual definition of this feature, is positively fascinating. As a stimulus to study and investigation, and in the arousing of enthusiasm for electrical work, the subject matter could not have been better chosen. Amongst other things, it says: "The animadversions that have been heaped upon electro-therapy by incompetent people, are merely the echoes of that past ignorant conservatism that bewailed the advent of the steam railway and of electric house lighting." This is absolutely true, and it is a peculiar fact that all familiar with medical discussions will recall, that, as a rule, the severest critics of electricity in medicine are those who freely admit having but little personal experience. A very valuable feature of this preface, which would better have appeared as an appendix, is a table giving the preference of every editor in electric apparatus, with the reasons for his views. This has the value and interest represented by practical tests, in the hands of those having large experience. The first eight chapters are most valuable, as they deal with the principles upon which rests the application of this force in medicine. That upon electro-physics should be carefully studied, as it will explain much upon which the practitioner has, as a rule, very vague ideas. Its language is plain, and all technicalities are explained in the text. Following this are 27 chapters, which take up in detail the different diseases and conditions in which electricity has been employed. In some chapters illustrative cases are given, and in all, the apparatus recommended, and the methods to be adopted in practice are fully discussed. The chapter on "The Electrical Treatment of Fibroid Tumors of the Uterus," by Drs. Grand and Famarque, assistants at the clinic of Apostoli, will well repay perusal. The names of the contributors to the work, are in themselves a guarantee that the best procurable literature upon the subject has been furnished. The best commendation that we can give the book is, that it is the only one published presenting the whole subject in a complete and masterly manner. It is, therefore, indispensable to any physician who desires to use electricity in an intelligent manner, and in the light of the experience of those who have made this little known subject a special study.

AN AMERICAN TEXT-BOOK OF THE DISEASES OF CHILDREN, INCLUDING SPECIAL CHAPTERS ON ESSENTIAL SURGICAL SUBJECTS; DISEASES OF THE EYE, EAR, NOSE, AND THROAT; DISEASES OF THE SKIN; AND ON THE DIET, HYGIENE, AND GENERAL MANAGEMENT OF CHILDREN. By American teachers. Edited by Louis Starr, M.D., Physician to the Children's Hospital, and Consulting Pediatrist to the Maternity Hospital, Philadelphia; late Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania, etc. Assisted by Thompson S. Westcott, M.D., Attending Physician to the Dispensary for Diseases of Children, Hospital of the University of Pennsylvania; Physician to Out-Patient Department, Episcopal Hospital, etc. Philadelphia: W. B. Saunders. pp. xiv—1190.

Since the publication of Keating's Cyclopedia of the Diseases of Children, no extensive treatise upon this important subject has been given to the profession. The editor states that the present volume is not an effort to add to the existing encyclopedias, "but to present to the profession a working text-book

which shall be closely limited to, while completely covering, the field of pediatrics." This object seems to have been very satisfactorily attained in the volume before us, and its eleven hundred and odd pages have given sufficient scope to treat the subject matter in detail. The size of the work has been kept in bounds by judicious condensation, the omission of references to journals and authorities, and the discussion only of the practical points in the management of the various diseases. While following the plan of the various "Text-books" that Mr. Saunders has given to the profession, in the individual authorship of separate chapters, it will be found that a remarkable harmony exists throughout, and that despite the multiplicity of authors, the general character of the work has not been marred. The volume opens with an introduction treating of the general hygienic conditions in early life, with a chapter on the artificial feeding of infants. The general suggestions contained in these chapters are sound and practical, though why a child should be bathed once a day during the first two and a half years of life, and yet, after the third year, have three baths a week assigned to him as "quite sufficient," is not quite plain. The continuance of this daily bath is certainly most desirable, and in many cases it is absolutely essential for ordinary cleanliness. Part I treats of the injuries incident to birth and diseases of the new born. Part II takes up the diathetic diseases. Part III comprises the acute infectious diseases. In this section it would certainly have been an advantage if the duration of infectiousness in each case had been mentioned, as this is a point upon which the medical attendant has frequently to give a decided opinion. The subsequent sections, seven in number, treat of general diseases not infectious; diseases of the blood; of the digestive organs; of the nervous system; of the respiratory system; of the heart; and of the genito-urinary system. The volume closes with three sections on diseases of the skin, diseases of the ear, and diseases of the eye. The addition of these chapters is in accordance with the plan of grouping subjects in the manner in which they generally occur in practice. As an example of this may be mentioned the inclusion of tracheotomy and intubation under the head of diphtheria, and of circumcision under that of phymosis. In speaking of the operation of circumcision, it seems strange that the author, when mentioning the Ricord forceps, with its fenestræ, should have omitted to mention the very great convenience which this instrument affords of passing the sutures that the incision is made. To cut through the fenestræ instead of in front of the forceps will, in ordinary hands, greatly complicate the operation. Throughout the volume the tendency of modern bacteriological teaching is plainly shown. There is no question about the exanthemata; they are admittedly of germ origin, and the distinction between true and false diphtheria or membranous croup is no longer only clinical, but can now be shown to be bacillary. Where there may be a doubt as to the germ origin of the disease, as in pneumonia, the influence of the writer is thrown in the direction of its acceptance. Even in infantile paralysis this is regarded as not improbable, and, in fact, as presenting the most reasonable hypothesis in many cases. The acceptance of these views will certainly result in much more satisfactory clinical work, and in greater precision in therapeutics. Taken as a whole, the book is a clean, plain, practical, and thoroughly up to date treatise on this subject. It is an exceedingly satisfactory book to read, from the absence of generalities, and to the practitioner, who usually has many little patients, it represents a good investment. There are a number of wood cuts, photo-engravings, and colored plates, all in the publisher's excellent style.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held December 30, 1895, the following were granted certificates to practise medicine in this State:

Gustave E. F. Anderson, San Francisco; Rush Med. Coll., Ill., March 28, '93.
 Thomas P. C. Barnard, N. Tonawanda, N.Y.; Med. Dept. Univ. Buffalo, N.Y., May 3, '92.
 S. F. Calhoun, New York; Med. Dept. Univ. City of New York, May 9, '95.
 Geo. H. Calkins, N. Tonawanda, N.Y.; Med. Dept. Univ. Buffalo, N.Y., May 2, '93.
 Annie E. Carveth, Redlands; Trinity Univ., Ontario, Canada, June 27, '93.
 Clinton H. Catherwood, San Francisco; Dartmouth Med. Coll., N.H., Nov. 26, '95.
 Frederick Fehleisen, San Francisco; Univ. of Wurzburg, Germany, July 16, '77.

A. J. Forget, Los Angeles; Univ. of Louvain, Belgium, Feb. 16, '94.
 Wm. E. Harwood, Redlands; Rush Med. Coll., N. Y., Feb. 24, '80.
 Henderson Hayward, Los Angeles; Med. Dept. Georgetown Univ., D. C., Mar. 2, '69.
 G. Wallace Kelley, San Francisco; Harvard Med. Coll., Mass., June 26, '78.
 J. William Laird, Pasadena; Baltimore Med. Coll., Md., April 15, '91.
 F. H. Lay, Golden Gate; Bellevue Hosp. Med. Coll., N. Y., Mar. 1, '78.
 Thos. R. McClintock, Los Angeles; Med. Coll. of Ohio, March 1, '70.
 D. P. McCord, San Francisco; Marion-Sims Med. Coll., Mo., Mar. 20, '94.
 O. H. Mennet, Los Angeles; Med. Coll. of Ohio, March 2, '74.
 J. S. Potts (lieu certificate), San Jose; Coll. Phys. and Surg., Keokuk, Ia., Feb. 13, '77.
 Thomas A. Roby, Ventura; Jefferson Med. Coll., Pa.; March 29, '84.
 H. E. Vreeland, Los Angeles; Rush Med. Coll., Ill., March 31, '91.
 F. A. Weir, Pasadena; Rush Med. Coll., Ill., Feb. 25, '79.
 Malcolm O. Austin, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Walter LeRoy Blodgett, Sacramento; Cooper Med. Coll., Cal., Dec. 5, '95.
 Rosa Meador Goodrich Boido, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Geo. W. Burgess, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Edgar O. Campbell, Santa Barbara; Cooper Med. Coll., Cal., Dec. 5, '95.
 Richard Henry Carter, Chico; Cooper Med. Coll., Cal., Dec. 5, '95.
 Frank H. Church, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Chas. V. Cross, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Wm. H. Crothers, San Jose; Cooper Med. Coll., Cal., Dec. 5, '95.
 Clarence W. Dodge, Oakland; Cooper Med. Coll., Cal., Dec. 5, '95.
 Wm. R. Dorr, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 E. C. Van Dyke, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Mary A. Fish, San Rafael; Cooper Med. Coll., Cal., Dec. 5, '95.
 Edward F. Glaser, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Frank Pierce Gray, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Lester C. Gregory, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Chas. E. Hablutzel, San Jose; Cooper Medical Coll., Cal., Dec. 5, '95.
 Frederick W. Harms, Pleasanton; Cooper Med. Coll., Cal., Dec. 5, '95.
 Emily G. Harrison, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Geo. T. Hesser, Calistoga; Cooper Med. Coll., Cal., Dec. 5, '95.
 Edmund E. Hill, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 James V. Hughes, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Fisher Randall Jordan, Oakland; Cooper Med. Coll., Cal., Dec. 5, '95.
 Rimpey Kodama, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Benj. F. Korts, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Eli Abraham Kusel, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Margaret J. Mahoney, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Wm. A. Meierdierks, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Theodore L. Meinhard, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 John C. Moore, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Neal M. Nelson, Alameda; Cooper Med. Coll., Cal., Dec. 5, '95.
 James H. O'Connor, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Amos C. Olmstead, Oakland; Cooper Med. Coll., Cal., Dec. 5, '95.
 R. E. Reese, Berkeley; Cooper Med. Coll., Cal., Dec. 5, '95.
 M. E. Rumwell, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 H. S. Schlageter, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Chas. R. Sexton, University; Cooper Med. Coll., Cal., Dec. 5, '95.
 Henry F. Walter, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Harry S. Walters, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 W. W. Wymore, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.
 Harry Partridge, San Francisco; Cooper Med. Coll., Cal., Dec. 5, '95.

CHAS. C. WADSWORTH, Secretary.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army (Division of the Pacific) from December 20, 1895, to January 20, 1896.

Leave of absence for two months, to take effect on or about January 21, 1896, with permission to go beyond sea, is granted Major Curtiss E. Munn, Surgeon, Benicia Barracks, California.

ITEMS.

Dr. William E. Hopkins has removed his office from 533 to 803 Sutter street, San Francisco, California.

Dr. H. M. Sherman has removed his office and residence from 705 Sutter street to 1303 Van Ness Ave., San Francisco. Hours, 1 to 4.

Dr. A. Lillencrantz has removed his office from the Academy of Sciences, 819 Market street, to 803 Sutter street, San Francisco. Hours, 1 to 4.

Dr. Donald McC. Gedge has removed from 406 Sutter street, San Francisco, California, to Honolulu, H.I., where he will reside permanently, making leprosy his special study.

Dr. A. B. McKee has opened an office in connection with Dr. C. E. Farnum in the Nucleus Building, corner of Third and Market streets, San Francisco. Dr. McKee has recently returned from Europe where he has spent the past three years in the study of ophthalmology, etc. During the past six months he has been associated with Dr. A. Barkan.